CASE NO. 08cv3100

ATTACHMENT NO. 1

EXHIBIT _____

TAB (DESCRIPTION) Part 2

Mid-West National Life Insurance Company of Tennessee
A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

LEGEND PRESCRIPTION DRUG EXPENSE RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms and DEFINITIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the maximum benefit amount and deductible stated herein.

BENEFITS

If an Insured Person Incurs Covered Expenses for Sickness or Injury, We will pay a benefit. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

You have the option to receive drugs either retail or through Our Mail Service Legend Prescription Drug Program.

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT
A Deductible of $100 will apply each Calendar Year to each Insured Person. After the Deductible is met, We will pay benefits subject to the applicable Benefit Payment Rate and Copayment specified below.

Participating Pharmacy	
Generic Drugs (not to exceed a 30 day supply)	100% less the $15.00 Copayment
Brand Name Drugs (not to exceed a 30 day supply)	25% discount
Non-Participating Pharmacy	0%
Mail Service Legend Prescription Drugs	
(Not to exceed a 90 day supply through Our designated mail service program)	
Generic Drugs	100% less the $30.00 Copayment
Brand Name Drugs	25% discount
Benefit Maximum	
Per Insured Person	$1,000 per Calendar Year

LEGEND PRESCRIPTION DRUGS FROM A PARTICIPATING/MAIL ORDER VENDOR:

1. If You have a prescription filled with a generic drug, You must pay the Pharmacy the Copayment amount set forth above for each separate prescription or refill for that generic drug. The Pharmacy will be paid directly by Us for the remainder of the cost of the prescription or refill.

2. If You have the prescription filled with a brand name drug, You will receive the discount set forth above for the cost of each separate prescription or refill for that brand name drug. The Pharmacy will be paid directly by Us for the remainder of the cost of the prescription or refill.

3. If You have a prescription filled with a brand name drug, and there is a therapeutic generic equivalent drug for that brand drug, We have special payment rules regarding reimbursement when a therapeutic generic equivalent drug could have been prescribed. We have created a list of generic drugs that the FDA has categorized as therapeutic equivalents to the corresponding brand name drug.

   Our payment will be based on the therapeutic generic equivalent drug fee schedule, which We have created for these therapeutic generic equivalent drugs or the actual drug charge, whichever is less. **You will be responsible for the generic drug Copayment set forth above and the difference in cost between Our payment and the actual cost of the brand name drug.**

   For example, assume You have a prescription for a brand name drug that costs $100, and the therapeutic equivalent generic has a fee schedule of $25. We will pay the $25, less the applicable Copayment amount ($10.00). **You must pay the generic drug Copayment amount plus the $75 balance remaining on the $100 charge.**

DEFINITIONS

Copayment means the amount which may be charged to the Insured Person by the Pharmacy for the dispensing, including each refill, of any Legend Prescription Drug, before We will make any payments under this Rider.

Deductible means the amount of Covered Expenses that an Insured Person must pay each Calendar Year before benefits will be paid. The Deductible does not include non-Covered Expenses.

Covered Expense means the actual charges for:

1. Legend Prescription drugs.
2. Compounded medication of which at least one ingredient is a Legend Prescription Drug.
3. Any other drug which, under the applicable state law, may be only dispensed upon written prescription of a Physician or other lawful prescriber.

Legend Prescription Drugs mean drugs, devices, biological and compounded prescriptions which can be dispensed only pursuant to a prescription; which by law are required to bear the legend "Caution - Federal Law prohibits dispensing without a prescription." The drug or device must be prescribed by an Insured Person's Physician or other licensed/authorized health care provider, and approved by the FDA for the treatment of the Insured Person's specific diagnosis or condition.

In certain situations, specific criteria including Medical Necessity criteria, may be established by Us and Our provider community, which defines whether certain drugs will be covered under this Rider.

We reserve the right to require prior authorization for any drug prior to payment under this Rider. You may call Us if You wish to obtain a list of drugs which require prior authorization.

Non-Participating Pharmacy means any Pharmacy which regularly dispenses Legend Prescription Drugs and has not entered into a Participation Agreement with Us. We will not pay for any benefits under this Rider for drugs that are purchased at a Non-Participating Pharmacy located in Our Provider Network Area.

Participating Pharmacy means any Pharmacy which regularly dispenses Legend Prescription Drugs and has entered into a Participation Agreement with Us.

Pharmacy means a facility where the practice of Pharmacy occurs.

Prescription Order means the request for a drug or device issued by a Physician or other qualified provider duly licensed to make such a request in the ordinary course of his/her professional practice.

EXCLUSIONS

We will not provide any benefits for:

1. Expenses incurred after coverage terminates under this Rider;
2. Non-legend drugs;
3. Devices of any type, even though such devices may require a Prescription Order, such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, hypodermic needles, syringes (except when used for treatment of diabetes), support garments, ostomy supplies, and other non-medical substances, or similar devices, regardless of intended use;
4. Immunization agents, allergy sera, biological sera, blood or blood products administered on an outpatient basis;
5. Anti-smoking aids (e.g. nicorette gum, nicotine patches);
6. Drugs labeled, "Caution - limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the Insured Person;
7. Products used for unapproved cosmetic indications;
8. Any illegal substance;
9. Drugs used to treat or cure baldness, and anabolic steroids used for body building;
10. Any charge for the administration of Legend Prescription Drugs or injectable insulin;
11. Drugs for participants covered under Medicare or Medicaid programs, or drugs paid by or covered under any benefit or insurance program;
12. Non-injectable vitamins or fluorides or health foods, health and beauty aids, cosmetics, nutritional or dietary supplements;
13. Drugs determined to be "less than effective" by the Drug Efficacy Study Implementation (DESI) Program. For example: Equagesic, Midrin, Cyclospasmol, and Vasodilan have been rated less-than-effective. The Omnibus Budget Reconciliation Act of 1981 has mandated the Health Care Financing Administration to ban reimbursement for less-than-effective drugs products by federal Medicare/Medicaid agencies;
14. Any medication, legend or not, which is consumed or administered at the place where it is dispensed;
15. Anorectic, Weight control drugs; or
16. Fertility drugs.

LIMITATIONS

The following dispensing limits will apply to each prescription:

1. **Participating Pharmacy** - No more than a 30 day supply or 100 unit doses, whichever is less, may be dispensed. No more than two refills of the same prescription may be dispensed in any one Calendar Year. For certain drugs, less than a 30 day supply or 100 unit doses may be dispensed.

2. **Mail Service Legend Prescription Drugs** - No more than a 90 day supply may be dispensed at any one time. For certain drugs, less than a 90 day supply may be dispensed.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: 06/21/2005

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE

Peggy G Simpson
SECRETARY

Philip T Myhr
PRESIDENT

Mid-West National Life Insurance Company of Tennessee

A Stock Company
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PHYSICIAN OFFICE VISIT BENEFIT RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the maximum benefits and Copayments shown for this Rider in the CERTIFICATE SCHEDULE.

Benefits payable under this Rider are not subject to the Certificate Deductible.

COVERED EXPENSES

We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit, up to the Maximum Benefit per visit, subject to the Copayment shown in the CERTIFICATE SCHEDULE. No benefits are payable for services such as routine examinations, immunizations, and preventive care.

Copayment means the amount the Insured Person is required to pay for specifically listed Covered Expenses. The Copayment for this Rider is shown in the CERTIFICATE SCHEDULE. Copayments do not count toward Deductibles or Coinsurance Maximums.

Benefits payable under this Rider will not be used to satisfy the Certificate Deductible.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: 06/21/2005

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OUTPATIENT CHEMOTHERAPY AND RADIATION THERAPY FOR CANCER TREATMENT RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the Daily Maximum Benefits, Coinsurance and the Lifetime Maximum Benefit Amount shown for this Rider in the CERTIFICATE SCHEDULE.

Benefits payable under this Rider are not subject to the Certificate Deductible.

COVERED EXPENSES

We will pay benefits for Covered Expenses incurred by an Insured Person, while this Rider is in force, for Outpatient Chemotherapy and Radiation Therapy. The condition for which Chemotherapy or Radiation therapy is provided must be first diagnosed, and the treatment must be received while coverage is in force under this Rider.

All Covered Expenses payable under this Rider are paid in lieu of Covered Expenses incurred under the Certificate and will not be used to satisfy the Certificate Deductible.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: 06/21/2005

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE

SECRETARY

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INJURY DEDUCTIBLE RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate, which are not inconsistent with the provisions of this Rider.

Covered Expenses incurred due to an Injury resulting in Hospital Confinement will be subject to the Injury Deductible shown on the CERTIFICATE SCHEDULE. This Injury Deductible will be in lieu of all other deductibles.

Injury Deductible means the amount of Covered Expenses that an Insured Person must pay for each Injury resulting in a Hospital Confinement before benefits will be paid. Injury Deductible does not include non-Covered Expenses and any copayments.

The Injury Deductible will be applied separately for each Injury for each Insured Person.

If more than one Insured Person in Your family is injured in the same accident, only one Injury Deductible must be satisfied for Covered Expenses associated with that accident.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Policy Date: 06/21/2005

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE

SECRETARY PRESIDENT

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URGENT CARE BENEFIT RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the maximum benefit amount, Copayment and Coinsurance shown for this Rider in the CERTIFICATE SCHEDULE.

Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Certificate and are not subject to and will not be used to satisfy the Certificate Deductible.

COVERED EXPENSES

We will pay benefits for Covered Expenses of an Insured Person while this Rider is in force, for Urgent Care Treatment of a Sickness not resulting in Hospital Confinement and for treatment of an Injury not resulting in Hospital Confinement. Covered Expenses will also include follow-up services for an Injury provided such services are rendered in the 45 days immediately following the Injury. The Copayment for Injury follow-up services will be reduced when rendered in a Physician's office, as shown in the CERTIFICATE SCHEDULE. Any follow-up services provided beyond 45 days following the Injury will not be considered a Covered Expense under this Rider.

For the purpose of this benefit, Urgent Care Treatment of a Sickness means treatment rendered in a facility providing urgent care (including but not limited to a Hospital Emergency Room) as the result of the sudden onset of a Sickness for which the Insured Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe that without immediate medical attention could reasonably be expected to result in:

1. Placing the Insured Person's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Urgent Care Treatment of a Sickness will not include any follow-up treatment or services related to that Urgent Care Treatment.

Under this Rider, Copayment means the amount the Insured Person is required to pay for specifically listed Covered Expenses before any benefits are payable and before application of the Coinsurance and/or maximum benefits. The Copayment for this Rider is shown in the CERTIFICATE SCHEDULE. Copayments and Coinsurance under this Rider do not count toward Deductibles or Coinsurance Maximums under the Certificate.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: 06/21/2005

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE

Peggy Y. Simpson
SECRETARY

Philip T. Myl
PRESIDENT

MW-25947

DUPLICATE

RMRXX97001

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AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the Group Policy and Certificate to which it is attached. It is subject to all the provisions of the Group Policy and Certificate, which are not inconsistent with this Amendatory Endorsement and is applicable to Certificateholders residing in Illinois.

1. The following disclosure has been added to the **face page** of the Certificate:

   This Certificate provides at a minimum the coverages or services required by the State of Illinois, or the laws of the state in which this Certificate has been issued.

2. The definitions of **Complications of Pregnancy, Eligible Dependent, Injury, Pre-Existing Condition** and **Transplant Procedure** under the **DEFINITIONS** section are hereby deleted in their entirety and replaced with the following:

   - **Complications of Pregnancy** means:
     1. Conditions requiring Hospital Confinement or treatment in an Outpatient Surgery Facility (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy, including but not limited to: non-elective cesarean section, acute nephritis, nephrosis, hyperemesis gravidarum, pre-eclampsia, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; or
     2. Termination of ectopic pregnancy and spontaneous termination of pregnancy occurring during a time that a viable birth is not possible.

     Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Sickness and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication.

   - **Eligible Dependent** means Your lawful spouse and Your unmarried natural and adopted children, including children placed in Your custody for the placement of adoption, step-children and grandchildren (if the grandparents have obtained an interim-court order that vests temporary custody of said grandchildren), who are under 19 years of age (the Limiting Age). The Limiting Age is extended from the child's 19th birthday to the child's 24th birthday if the child is enrolled as a full time student and attends classes regularly at an accredited college or university.

   - **Injury** means accidental bodily injury or injuries sustained by an Insured Person which directly causes the loss, independent of Sickness, bodily infirmity and which occurs after the Insured Person's coverage has become effective and while the coverage is in force.

   - **Pre-Existing Condition** means a medical condition, Sickness or Injury not excluded by name or specific description for which:
     1. Medical advice, Consultation, or treatment was recommended by or received from a Physician within the two year period before the Effective Date of Coverage; or
     2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the one year period before the Effective Date of Coverage.

   - **Transplant Procedure** means Medically Necessary human organ and tissue transplants.

3. Item number 1 in the **Hospital** definition under the **DEFINITIONS** section is hereby revised as follows:

   1. Maintain on its premises organized facilities for, or facilities having an agreement to provide, medical, diagnostic and surgical care for sick and injured persons on an inpatient basis.

4. The following definition has been added to the **DEFINITIONS** section:

   Outpatient Contraceptive Service means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. This does not include services related to an abortion or permanent sterilization that requires a surgical procedure.

5. The following provision has been added to the **EFFECTIVE DATE OF COVERAGE** section:

   Adopted Children
   Your adopted child(ren) will be provided coverage after the Effective Date from the moment the child is placed in Your physical custody for adoption for 31 days. To continue coverage beyond 31 days, You must send written notice directing Us to add the adopted child to Your coverage. We must receive this notice within 31 days of the adopted child's date of placement and the notice must be accompanied by any required additional premium. Coverage will end if the placement is disrupted prior to legal adoption and the child is removed from the placement.

6. The **You** provision under the **TERMINATION OF COVERAGE** section is hereby deleted and replaced with the following:

   You

   Your coverage will terminate and no benefits will be payable under this Certificate and the attached Riders, if any:

   1. At the end of the period for which premium has been paid;
   2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination. No refund will be payable if Your mode is monthly;
   3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
   4. On the date of fraud or misrepresentation by You;
   5. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
   6. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
   7. On the date an Insured Person is no longer a permanent resident of the United States.

7. The **Extension of Benefits** provision under the **TERMINATION OF COVERAGE** section is hereby deleted and replaced with the following:

   Extension of Benefits

   If an Insured Person is Totally Disabled at the time the Group Policy terminates, benefits will be payable for Covered Expenses incurred due to the Injury which caused such Total Disability. Such benefits are subject to the same terms and conditions of the Group Policy if the Group Policy had remained in force. This extension of benefits will cease on the earliest of:

   1. The date on which the Total Disability ceases; or
   2. The end of the 12 month period immediately following the date on which the Insured Person's insurance terminated.

8. The following Covered Expenses are added to the **BENEFITS** section. Unless otherwise stated, all Covered Expenses are subject to the Deductible, Coinsurance and Lifetime Maximum Amount shown in the CERTIFICATE SCHEDULE; the Maximum Benefit, benefit and/or Aggregate Maximum Amounts, if any, shown in the CERTIFICATE SCHEDULE; and the Coinsurance Maximum and Co-payments, if any, shown in the CERTIFICATE SCHEDULE. Unless otherwise stated, these Covered Expenses are also subject to the **EXCLUSIONS AND LIMITATIONS** and all other provisions of the Group Policy.

- **Mammography Screening Benefit**

  Covered Expenses include charges for Low-Dose Mammography screening for the presence of occult breast cancer for a female Insured Person as follows:

  (1) One baseline mammogram for female Insured Persons age 35 to 39;
  (2) An annual mammogram for female Insured Persons age 40 and older; and
  (3) A mammogram at the age and intervals considered Medically Necessary by a Physician for female Insured Persons under 40 years of age and having a family history of breast cancer or other risk factors.

  "Low-Dose Mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast.

- **Minimum Stay Requirements for Mastectomies**

  If an Insured Person incurs Covered Expenses for a mastectomy, coverage will be provided for inpatient care for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the Insured Person. Coverage will also be provided for a post-discharge Physician office visit or in-home nurse visit to verify the condition of the Insured Person in the first 48 hours after discharge.

- **Breast Reconstruction Benefit**

  Covered Expenses include the charges for breast reconstruction for an Insured Person who elects breast reconstruction in connection with a mastectomy. Such coverage shall be provided in a manner determined in consultation with the attending Physician and Insured Person. Benefits shall include coverage for:

  1. Reconstruction of the breast on which the mastectomy has been performed;
  2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  3. Prostheses and treatment for physical complications in all stages of mastectomy, including lymphedemas.

  When a mastectomy is performed and there is no evidence of malignancy, coverage provided for prosthetic devices and reconstructive surgery will be limited to 2 years from the date of the mastectomy.

- **Minimum Stay Requirements for Maternity Care Benefit**

  This benefit is applicable to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for Complications of Pregnancy as defined in the Certificate.

  If an Insured Person incurs Covered Expenses for cesarean section delivery, coverage will be provided for a minimum of 96 hours of inpatient care following a cesarean section for the Insured Person and her newborn.

  If a decision is made to shorten the length of stay less than the minimum stated above, the decision shall be made by the attending Physician, obstetrician, or pediatrician in consultation with the mother.

The following benefit is effective on the later of January 1, 2006 or the Certificate Date:

- **Pap Smear Test Benefit**

  Covered Expenses include charges for an annual Pap smear test for any female Insured Person and Surveillance Tests for Ovarian Cancer for any female Insured Person who is At Risk for Ovarian Cancer.

  For the purpose of this benefit, "At Risk for Ovarian Cancer" means (1) having a family history (a) with one or more first-degree relatives with ovarian cancer; (b) of clusters of women relatives with breast cancer, or (c) of nonpolyposis colorectal cancer, or (2) testing positive for BRCA1 or BRCA2 mutations.

  For the purpose of this benefit, "Surveillance Tests for Ovarian Cancer" means annual screening using (1) CA-125 serum tumor marker testing, (2) transvaginal ultrasound, and (3) pelvic examination.

- **Prostate Screening Benefit**

  Covered Expenses include the fees charged for an annual digital rectal examination and a prostate-specific antigen test for the early detection of prostate cancer at the following age intervals for:

  1. asymptomatic men age 50 and over;
  2. African-American men age 40 and over; and
  3. men age 40 and over with a family history of prostate cancer.

- **Colorectal Cancer Screening**

  Covered Expenses include the charges for all colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by Your Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

- **Diabetes Self-Management Training and Education**

  Covered Expenses include charges for outpatient Self-Management Training and medical nutrition education, equipment and supplies for the treatment of type 1, type 2, and gestational diabetes mellitus. Diabetes Self-Management Training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes management and shall be limited to:

  1. (3) Medically Necessary visits upon initial diagnosis; and
  2. (2) Medically Necessary visits upon determination of a significant change in the Insured's condition.

  "Diabetes Self-Management Training" means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes Self-Management Training shall include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy.

  A "Significant Change" in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a Significant Change in medical condition that would require a significantly different treatment regimen.

  Covered Expenses include charges for regular foot care exams performed by a Physician.

- **Outpatient Contraceptive Benefit**

  Covered Expenses include the charges for Outpatient Contraceptive Services and devices approved by the Food and Drug Administration.

- **Osteoporosis**

  Covered Expenses include the charges for Medically Necessary bone mass measurement and for the diagnosis and treatment of osteoporosis.

9. The **Hospital Room and Board, Miscellaneous Hospital Inpatient Charges, Outpatient Surgery Facility Charges** and the **Anesthesiology Benefit** provisions are hereby amended to include the following:

   Covered Expenses also include charges for general anesthesia and related services provided in conjunction with dental care that is provided to an Insured Person in a Hospital or an Ambulatory Surgical Treatment Center, if:

   1. the Insured Person is a child age 6 or under;
   2. the Insured Person has a medical condition that requires hospitalization or general anesthesia for dental care; or
   3. the Insured Person is Disabled.

   For the purpose of this benefit **"Ambulatory Surgical Treatment Center"** means any institution or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures, as evidenced by use of facilities by Physicians or podiatrists in the performance of surgical procedures which constitutes more than 50 percent of the activities at that location.

   For the purpose of this benefit **"Disabled"** means a person regardless of age, with a chronic disability if the chronic disability meets all of the following conditions:

   1. it is attributable to a mental or physical impairment or combination of mental and physical impairments;
   2. it is likely to continue; and
   3. it results in substantial functional limitations in one or more of the following areas of major life activity:

      (a) self-care;
      (b) receptive and expressive language;
      (c) learning;
      (d) mobility;
      (e) capacity for independent living; or
      (f) economic self-sufficiency.

10. The **Transplant Procedures** benefit under the **BENEFITS** section has been deleted in its entirety and replaced as follows:

    - **Transplant Procedures**

      Covered Expenses include charges incurred by an Insured Person as a recipient of an organ transplant procedure, while Hospital Confined, provided such transplant procedure is commonly or customarily recognized by the medical profession as appropriate treatment of a Sickness or Injury.

      Covered Expenses do not include charges that are determined by the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the Federal Department of Health and Human Services to be Experimental or Investigational or if there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.

      Covered Expenses do not include charges incurred by or relating to an organ donor.

Benefits are not payable for animal organ or artificial organ transplants or for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a Physician prescribes such items.

11. The lead sentence under the **EXCLUSIONS AND LIMITATIONS** section is hereby deleted and replaced with the following:

We will not provide any benefits for any loss caused by or resulting from:

12. The eighth exclusion under the **EXCLUSIONS AND LIMITATIONS** section is hereby deleted and replaced with the following:

8. Drug abuse or addiction, or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a Physician;

13. The ninth exclusion under the **EXCLUSIONS AND LIMITATIONS** section is hereby deleted and replaced with the following:

9. Being intoxicated or under the influence of intoxicants that which is defined and determined by the laws of the state where the loss or cause of the loss was incurred, hallucinogens, narcotics or other drugs, unless taken as prescribed by a Physician;

14. The thirteenth exclusion under the **EXCLUSIONS AND LIMITATIONS** section is hereby deleted and replaced with the following:

13. Mandibular or maxillofacial Surgery, unless related to a birth defect of a newborn covered under this Certificate, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion;

15. The nineteenth exclusion under the **EXCLUSIONS AND LIMITATIONS** section is hereby deleted and replaced with the following:

19. the commission or attempt to commit a felony, or while engaging in an illegal occupation;

16. The thirtieth exclusion under the **EXCLUSIONS AND LIMITATIONS** section is hereby deleted and replaced with the following:

30. Any types of hernia, hemorrhoids, tonsils or adenoids unless the loss is incurred 6 months after the Insured Person becomes covered under this Certificate;

17. The **Claim Determination Period** provision under the **COORDINATION OF BENEFITS** section, regarding item 2 of **"The rules that set the order of benefit determination are:"** section, is hereby deleted and replaced with the following:

2. When a dependent is a child covered under separate Plans of each parent and where the parents have Joint Custody, the Plan covering the parent whose date of birth (month and day) precedes the other in the Calendar Year shall be primary; except:
   a) where both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time; or
   b) where the parents are separated or divorced and the parent with custody of the child has not remarried, then the Plan covering the parent with custody shall be primary; or
   c) where the parents are divorced and the parent with custody of the child has remarried; then: (i) the Plan covering the parent with custody shall be primary, or (ii) the Plan covering the step-parent of the child shall be primary to that of the parent without custody; or
   d) notwithstanding subparagraphs a), b), and c) above, where the parents are divorced or separated and there is a court decree establishing the financial responsibility of medical or other health care expenses with respect to the child of one parent, then the Plan covering the parent with the financial responsibility shall be primary; and

18. The first paragraph in the **Claim Payments** provision under the **GENERAL PROVISIONS** section is hereby deleted and replaced with the following:

Claim Payments

We will pay or deny all benefits due under the Group Policy no later than 30 days from due proof of loss. If claim payment is determined and reimbursement is not made within 30 days from receipt of due proof of loss, starting on the 30th day, interest at a rate of 9% per annum will accrue until the claim is paid. If We deny a claim, written notice will be supplied no later than 30 days from receipt of due proof of loss.

19. The **Right of Reimbursement** provision under the **GENERAL PROVISIONS** section is hereby delete and replaced with the following:

Right of Reimbursement

If an Insured Person incurs expenses for a Sickness or Injury that occurred due to the negligence of a third party:

a) We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured Person, Insured Person's parents, if the Insured Person is a minor, or Insured Person's legal representative as a result of that Sickness or Injury; and

b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury.

We shall have the right to reimbursement out of all funds the Insured Person, the Insured Person's parents, if the Insured Person is a minor, or the Insured Person's legal representative, is or was able to obtain for the same expenses We have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability.

Any benefits payable pursuant to this Amendatory Endorsement will not be duplicated under any optional benefit rider that may be attached to the Insured Person's Certificate.

The provisions of this Amendatory Endorsement are effective on the Certificate Date, the Effective Date shown herein (if any), or as required by law, whichever is later.

In Witness whereof, the Insurance Company has caused this Amendatory Endorsement to be signed by its President and Secretary.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE

SECRETARY

PRESIDENT

OFFICIAL NOTICE TO ALL CERTIFICATE HOLDERS

While our Company always strives to render the finest quality of service to our Insureds, it may be that at some point in the life of our association, we may not perform in accordance with the manner of standards you would like to be applied to any given situation. In that event, you may contact our Company by writing the following:

Insurance Center
P.O. Box 982010
North Richland Hills, Texas 76182-8010

If, after having corresponded with this Department, you are not satisfied with the result, you may write to the Public Service Division of the Department of Insurance at the following address:

Director of Insurance
Illinois Department of Insurance
Public Service Division
215 East Monroe Street
Springfield, Illinois 62767

MW/2004 APP 06/04 (06/04)

☒ Cover America Plus (#25906)
Ded: ☐ $1,000 ☐ $2,000 ☒ $3,000 ☐ $5,000 Misc. Hosp.: ☒ 30x ☐ 60x
R&B: ☐ $300 ☐ $400 ☐ $500 ☐ $600 ☒ $800 ☐ $1,000 ☐ $1,200 ☐ $1,400
Surgery Benefit: ☒ 10x Outpatient Surgery Facility: ☒ 7x ☐ 10x
☐ Personal Choice (#25907)
In Netwk. Ded: ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000
Aggregate Maximum: ☐ $500,000 ☐ $1,000,000
☐ Cover America Together (#25939)
Ded: ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000
Coinsurance Amount: ☐ 100% ☐ 80% ☐ 50%
☒ Accident Benefit Care (#25924) Cannot be sold with health
Ded: ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000
R&B: ☐ $300 ☐ $400 ☐ $500 ☐ $600 ☐ $700
Surgery Benefit: ☐ 2x ☐ 3x Outpatient Surgery Facility: ☐ 9x ☐ 12x

Payment Mode: ☒ M ☐ Q ☐ SA ☐ A 872.25

Agency Lead #_____ ☐ Ref. ☐ PDL

If any family member is declined, do you still want coverage?
☐ Yes or ☐ No

Special Request(s):

$ 69011 04009

Additional/Optional Benefits

☐ Continued Care Benefit (#25883)
☒ Injury Deductible Benefit (#25911)
☒ Ambulatory Care (#25885 9/03)
☐ Plan A $50 Copay ☒ Plan B $250 Copay ☐ Plan C $500 Copay
☐ Outpatient Accident (#25882) Ded $_____ Max $_____
☐ Pregnancy/Childbirth Benefit (#25884)
☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $4,000 ☐ $5,000 ☐ $6,000
☐ Accumulated Covered Expense (#25890)
☒ Urgent Care (#25947) Copay $ 250 Max $ 1000
☒ Physician's Office Visit (#25886) ☒ 1 visit ☐ 2 visits
☐ Family Wellness (#25888 9/03) Coinsurance_____% Max $_____
☐ Return of Premium (#25044)

☒ Outpatient Chemo/Radiation Therapy (#25910)
☒ Legend RX Drug (#25892) Ded. $ 100 Max. $ 1000
☒ Dental Plan (#25879) ☒ Vision (#25213)
☐ Cancer Wise (#25616) $10,000
☐ Primary Insured ☐ Spouse ☐ Children
☐ Safety Net Life Plan (#25430) ☐ Optional ALBR (#25894)
Primary Insured – Face Amount $_____
Beneficiary's Name:_____
Spouse – Face Amount $_____
Beneficiary's Name:_____
Dependent – Face Amount $_____
Beneficiary's Name:_____
☐ Other_____

Enrollment Application for: Mid-West National Life Insurance Company of Tennessee • Oklahoma City, Oklahoma 73118

1. SCHEDULE OF FAMILY MEMBERS – FIGURE HEALTH PREMIUM AT AGE LAST BIRTHDAY

PLEASE PRINT (Full Name)	Sex	Relationship	Social Security #	Birthdate	Birthplace	Age	Height	Weight
(1) Fred Plambeck	M	Primary	327-42-4213	6-4-1949	IL	56	6'	182
(2) Susan Plambeck	F	Spouse	342-50-3529	11-10-1956	IL	48	5'7	155
(3) Megan Chartier	F	Child	342-84-4759	8-14-1988	IL	15	5'5'	160
(4)								
(5)								

2. Marital Status: ☐ Single ☒ Married
3. Applicant's Home Address:
Address 29869 Pioneer Grove
City Lacy State IL Zip 60013
County McHenry
Daytime Telephone (847) 516-1267
Home Telephone (847) 516-7267
Email Address none
Fax Number (_____) none
4. Are all members U.S. Citizens? yes
If "No," please explain:_____
How long in the U.S.?_____
5. Occupation and duties of adult family members:
(1) Carpenter
(2) Fund raising
6. Are all members between the ages of 19 and 24 full-time students? no
If "Yes," name school_____
Hours currently enrolled_____
If "No," which Applicant?_____
Explain_____
7. Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?
If "Yes," whom? nl
Estimated date of delivery none
8. Is any Applicant eligible for or covered under Medicare or Medicaid? If "Yes," whom? no
9. Do you currently have health insurance? no
If "Yes," is it ___ Group or ___ Individual, names of companies, certificate/policy number, and types of coverage?_____

Date of cancellation_____
Will existing health coverage be replaced or changed if proposed health coverage is issued? ___ Yes ___ No
If "No," reason_____
10. Does any Applicant to be insured engage in any hazardous sport or activity? (e.g.: flying, diving, skydiving, racing.)
Name: no Activity: none
11. During the past ten years, has any person to be insured had insurance declined, rated, ridered, or otherwise changed?
If "Yes," which Applicant? nl Date / /
Reason: none
Company:_____
12. a) Applicant's Doctor Dr DiLorio
Address 500 W HWY 22
City Barrington State IL Zip 60098
Telephone Number (847) 381-3000
b) Spouse's Doctor Dr DiLorio
Address 500 W HWY 22
City Barrington State IL Zip 60098
Telephone Number (847) 381-3000
c) Child(ren)'s Doctor Dr DiLorio
Address 500 W HWY 22
City Barrington State IL Zip 60098
Telephone Number (847) 381-3000
13. Is any Applicant presently taking any medications?
Who? none
What?_____
Why?_____
14. Has any Applicant used tobacco products in the last 12 months? yes If "Yes," who and what? Primary & Spouse - CIGARETTES

15. Have you or any Applicant ever had your driver's license suspended, revoked or ever received any citations for driving while under the influence (i.e. DWI or DUI)? NO If "Yes," list details.

16. a) When was the last time the Applicant visited a doctor? 11-05
Symptoms? Check up Results? OK Recommendations? None
b) When was the last time the spouse visited a doctor? 5-05
Symptoms? check up Results? OK Recommendations? None
c) When was the last time the child(ren) visited a doctor? 3-05
Symptoms? Check up Results? OK Recommendations? None

17. Have you or any Applicant EVER had symptoms, been diagnosed, received medical advice or been treated for (if "Yes," circle applicable condition):

	YES	NO
a) Heart disorder, including murmur, heart attack, chest pain, artery or vein disorder, high blood pressure or stroke?	☐	☒
b) Diabetes, hypoglycemia, goiter or thyroid disorder?	☐	☒
c) Blood or spleen disorder including anemia or leukemia?	☐	☒
d) Breast or reproductive organ disorder?	☐	☒
e) Cancer, cyst, tumor or neoplasm?	☐	☒
f) Respiratory disorder, including asthma, bronchitis, COPD, emphysema, lung disease or breathing problems?	☐	☒
g) Kidney, urinary bladder, urinary tract, stones or prostate disorders?	☐	☒
h) Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, enteritis, hepatitis or pancreatitis?	☐	☒
i) Hernia, hemorrhoids, polyps or rectal disorder?	☐	☒
j) Eye, ear, nose or throat disorders?	☐	☒
k) Skin disorders, burns, lacerations, dermatitis, boils or chronic rashes?	☐	☒
l) Back, spine, arm or leg disorder or arthritis, gout, bursitis or neuritis?	☐	☒
m) Complications of pregnancy and/or Caesarean section?	☐	☒
n) Brain disorder, epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury or chronic headaches?	☐	☒
o) Mental or nervous disorder, depression, anxiety, alcoholism or drug addiction?	☐	☒
p) Been diagnosed by a physician for any disorder of the blood or immune system including AIDS?	☐	☒

18. Any other medical or surgical advice, hospitalizations, treatment, operations, or testing in the last five (5) years? ☒ NO

19. IMPORTANT: Give complete details of any "Yes" answers to questions 17 through 18.

Name	Nature of Illness or Accident (Include Diagnosis, Operations, and Medications)	Date Started	Date Stopped	Operation	Hospitalized	Doctor's Name and Address
Dr Pinos Susan Plambeck	had hysterectomy	3-10-05	3-14-05	☒ Yes ☐ No	☒ Yes ☐ No	Dr. Pinos 847-382-2320 27401 W IVY 22 Barrington IL 60010
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	

If additional space is needed, use separate paper to record complete information with signature of Applicant.

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the policy/certificate is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading is guilty of insurance fraud and is subject to criminal and/or civil penalties.

I have received and understand the Notification of Consumer Report and Medical Information Bureau Pre-Notice.

Dated at: City Cary State IL Month June Day 15 Year 2005

Signed X [signature] Applicant (for and in behalf of above named person)

Signed X Susan Plambeck Applicant, Spouse, Parent (if minor, next of kin or legal representative

To Be Answered By Agent:
I certify that each question on this application was asked by me of the Applicant(s) named above, and all answers are accurately recorded.

X [signature] Signature of Licensed Agent

Roberto Elliott Print Full Name

113906 Agent Number

MW-25098-APP (8/00)

(06/04)

a) Coverage:

The Illinois Life and Health Insurance Guaranty Association provided coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

1) life insurance, health insurance, or annuity contracts;
2) life, health or annuity certificates under direct group policies or contracts;
3) unallocated annuity contracts; and
4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

b) Exclusions From Coverage:

1) The Guaranty Association does not provide coverage for:
   A) any policy or portion of a policy for which the individual has assumed the risk;
   B) any policy of reinsurance (unless an assumption certificate was issued);
   C) interest rate guarantees which exceed certain statutory limitations;
   D) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
   E) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer, or
   F) any stop loss insurance.
2) In addition, persons are not protected by the Guaranty Association if:
   A) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
   B) their policy was issued by an organization which is not a member insurer of the Association.

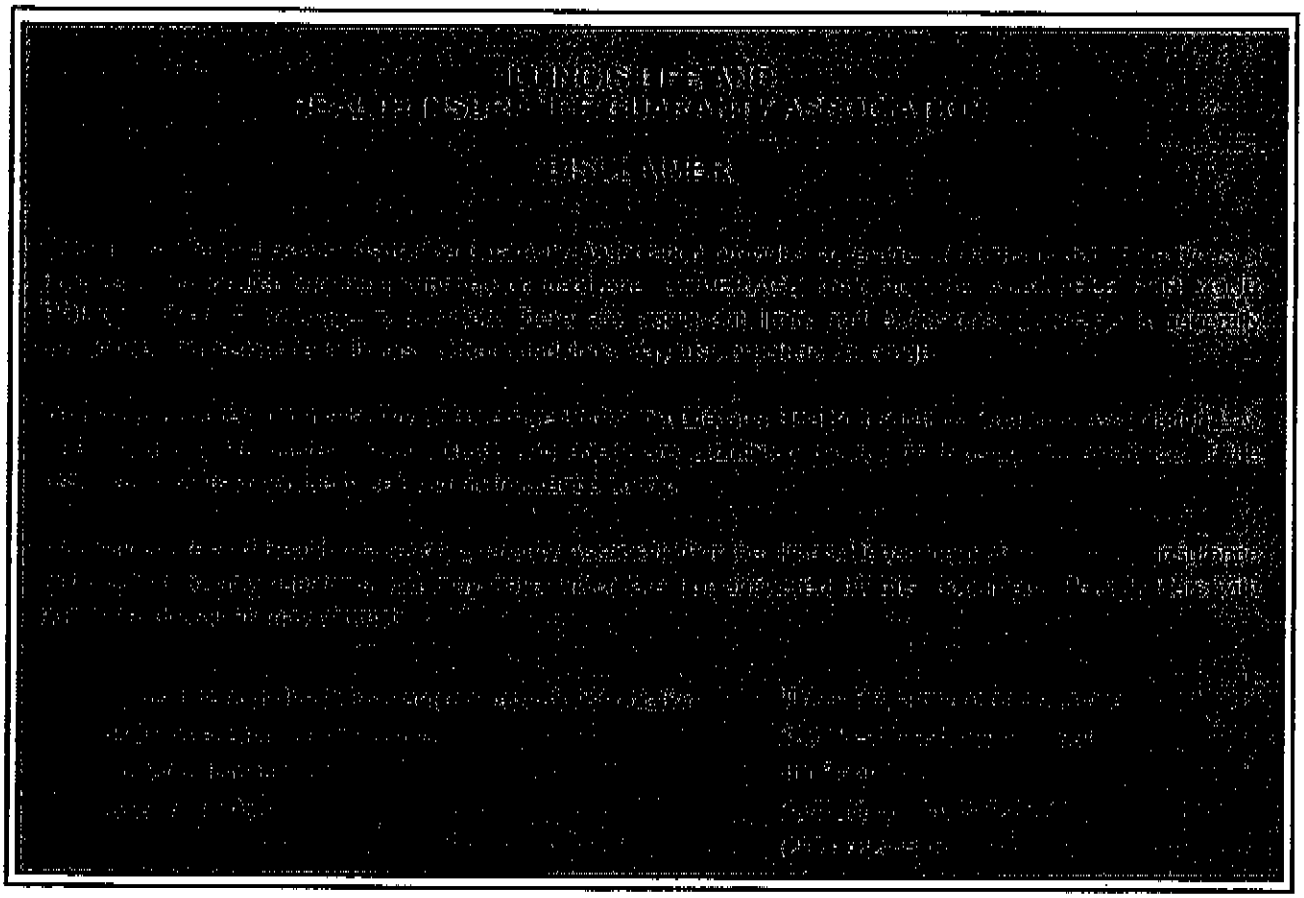
c) Limits On Amount Of Coverage:

1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Associations's liability is limited to the lesser of either:
   A) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
   B) with respect to any one life, regardless of the number of policies, contracts or certificates:
      i. in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
      ii. in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
      iii. with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other that those issued to certain governmental retirement plans is $5,000,000 in benefits per contractholder, regardless of the number of contracts.

2) However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

ILLINOIS
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.



SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law")(215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

GROUP DENTAL INSURANCE CERTIFICATE

IMPORTANT NOTICE ABOUT STATEMENTS IN THE ENROLLMENT APPLICATION

The attached enrollment application is a part of this Certificate. Please read it and check it carefully. This Certificate is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect enrollment application may cause Your coverage to be voided, or a claim to be reduced or denied.

10 DAY RIGHT TO EXAMINE THE CERTIFICATE

It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Certificate to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Certificate Date, refund all premiums paid and treat the Certificate as if it were never issued.

RENEWABILITY

This Certificate is guaranteed renewable to age 65, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of this Certificate. The Company reserves the right to change the applicable table of premium rates on a Class Basis. On each anniversary of the Certificate Date, the premium for the Certificate may change in amount by reason of an increase in the age of an Insured Person.

This Certificate is a legal contract between You and Us. This Certificate provides scheduled dental care benefits only and is not intended to cover all dental care expenses.

Peggy G. Simpson — SECRETARY

Philip T. Myhr — PRESIDENT

This Certificate provides limited dental care benefits only.
Please read it carefully.

DUPLICATE

TABLE OF CONTENTS

CERTIFICATE SCHEDULE

COVERAGE IS PROVIDED UNDER GROUP POLICY NO.: 00422

ISSUED TO GROUP POLICYHOLDER: Alliance for Affordable Services

PRIMARY INSURED: FRED PLAMBECK

COVERED DEPENDENTS: SUSAN MEGAN

CERTIFICATE NUMBER: 444375799 CERTIFICATE DATE: 06/21/2005

INITIAL PREMIUM: $46.00 MODE OF PAYMENT: MONTHLY

SCHEDULE OF BENEFITS

DEDUCTIBLE PER INSURED PERSON: $50 PER CALENDAR YEAR
DEDUCTIBLE FAMILY LIMIT: 3 PER FAMILY EACH CALENDAR YEAR

THE DEDUCTIBLE DOES NOT APPLY TO CLASS I COVERED EXPENSES.

BENEFIT MAXIMUMS:
EACH CALENDAR YEAR THAT THE INSURED PERSON'S COVERAGE IS IN FORCE:

FIRST CALENDAR YEAR	$1,000 PER EACH INSURED PERSON
SECOND CALENDAR YEAR	$1,000 PER EACH INSURED PERSON
THIRD CALENDAR YEAR AND EACH PLAN YEAR THEREAFTER	$1,000 PER EACH INSURED PERSON

WAITING PERIODS:

COVERED EXPENSES IN CLASS I	NO WAITING PERIOD
COVERED EXPENSES IN CLASS II	4 MONTH WAITING PERIOD
COVERED EXPENSES IN CLASS III	12 MONTH WAITING PERIOD

COVERED EXPENSES - SCHEDULED BENEFIT AMOUNTS:

CLASS I

PREVENTATIVE

0110	INITIAL ORAL EXAMINATION	23.00
0120	PERIODIC ORAL EVALUATION (12 MONTH INTERVALS)	13.00
0130	EMERGENCY ORAL EXAMINATION	26.00
1110	PROPHYLAXIS - ADULT (6 MONTH INTERVALS)	27.00
1120	PROPHYLAXIS - CHILD (6 MONTH INTERVALS)	23.00
1203	TOPICAL APPLIC FLUORIDE PXS NOT INCL - CHILD (12 MONTH INTERVALS)	13.00
1351	SEALANT - PER TOOTH (36 MONTH INTERVALS)	6.00
9110	PALLIATIVE (ER) TX - DENTAL PAIN - MINOR PROCEDURE	16.00

DIAGNOSTIC

0210	INTRAORAL - COMPLETE SERIES (INCLUDING BITEWINGS, 36 MONTH INTERVALS)	47.00

DIAGNOSTIC (CONTINUED)

0220	INTRAORAL - PERIAPICAL - FIRST FILM	8.00
0230	INTRAORAL - PERIAPICAL - EACH ADDITIONAL FILM	6.00
0240	INTRAORAL - OCCLUSAL FILM	11.00
0270	BITEWINGS - SINGLE FILM (12 MONTH INTERVALS)	15.00
0272	BITEWINGS - TWO FILMS (12 MONTH INTERVALS)	15.00
0274	BITEWINGS - FOUR FILMS (12 MONTH INTERVALS)	20.00
0330	PANORAMIC FILM	37.00
0340	CEPHALOMETRIC FILM	50.00

CLASS II

BASIC RESTORATIVE

2110	AMALGAM - ONE SURFACE, PRIMARY	15.00
2120	AMALGAM - TWO SURFACES, PRIMARY	20.00
2130	AMALGAM - THREE SURFACES, PRIMARY	25.00
2131	AMALGAM - FOUR OR MORE SURFACES, PRIMARY	29.00
2140	AMALGAM - ONE SURFACE, PERMANENT	15.00
2150	AMALGAM - TWO SURFACES, PERMANENT	22.00
2160	AMALGAM - THREE SURFACES, PERMANENT	26.00
2161	AMALGAM - FOUR OR MORE SURFACES, PERMANENT	33.00
2330	RESIN - ONE SURFACE, ANTERIOR	21.00
2331	RESIN - TWO SURFACES, ANTERIOR	27.00
2332	RESIN - THREE SURFACES, ANTERIOR	33.00
2335	RESIN - FOUR+ SURF OR INVL INCISAL ANGLE (ANTERIOR)	43.00

ENDODONTICS

3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	19.00
3310	ROOT CANAL - ANTERIOR (EXCLUDING FINAL RESTORATION)	119.00
3320	ROOT CANAL - BICUSPID (EXCLUDING FINAL RESTORATION)	128.00
3330	ROOT CANAL - MOLAR (EXCLUDING FINAL RESTORATION)	133.00
3340	ROOT CANAL - FOUR CANALS	0
3350	APEXIFICATION	0
3351	APEX./RECAL - INITIAL VISIT (AP. CLOS./CAL.REP.ETC.)	19.00
3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR	106.00
3450	ROOT AMPUTATION - PER ROOT	33.00
3920	HEMISECTION (INC ROOT REMOVAL) NOT INC ENDO	76.00
3950	CANAL PREP AND FITTING OF PREFORMED DOWEL/POST	24.00

ORAL SURGERY

7110	EXTRACTION - SINGLE TOOTH	19.00
7120	EXTRACTION - EACH ADDITIONAL TOOTH	19.00
7130	ROOT REMOVAL - EXPOSED ROOT	14.00
7210	SURG REM ERUP TOOTH REQ FLAP/BONE REM/SEC TOOTH	19.00
7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	38.00
7230	REMOVAL OF IMPACTED TOOTH - PARTIAL BONY	52.00
7240	REMOVAL OF IMPACTED TOOTH - COMPLETE BONY	52.00

ORAL SURGERY (CONTINUED)

7241	REM IMPAC TOOTH - COMP BONY/UNUSUAL COMPLICATION	62.00
7250	SURG REM OF RESIDUAL TOOTH ROOTS (CUTTING PROC)	29.00
7285	BIOPSY OF ORAL TISSUE - HARD	25.00
7286	BIOPSY OF ORAL TISSUE - SOFT	25.00
7320	ALVEOLOPLASTY NOT IN CONJUNC WITH EXTS - PER QUAD	74.00
7430	EXCISION OF BENIGN TUMOR LESION < 1.25 CM	62.00
7431	EXCISION OF BENIGN TUMOR LESION > 1.25 CM	62.00
7440	EXCISION OF MALIGNANT TUMOR LESION < 1.25 CM	62.00
7441	EXCISION OF BENIGN/MALIGNANT TUMOR LESION > 1.25 CM	62.00
7450	REMOVAL OF ODONTOGENIC CYST/TUMOR/LESION < 1.25 CM	65.00
7451	REMOVAL OF ODONTOGENIC CYST/TUMOR/LESION > 1.25 CM	65.00
7460	REM OF NONODONTOGENIC CYST/TUMOR/LESION < 1.25 CM	65.00
7461	REM OF NONODONTOGENIC CYST/TUMOR/LESION > 1.25 CM	65.00
7465	DESTRUCTION/LESION BY PHYSICAL METHODS	65.00
7470	REMOVAL OF EXOSTOSIS-MAXILLA OR MANDIBLE	95.00
7510	I & D ABSCESS INTRAORAL - SOFT TISSUE	31.00
7960	FRENULECTOMY (FRENECTOMY/FRENOTOMY) SEP. PROC.	59.00
7970	EXCISION OF HYPERPLASTIC TISSUE / PER ARCH	71.00

PERIODONTICS

4210	GINGIVECTOMY OR GINGIVOPLASTY - PER QUADRANT	73.00
4211	GINGIVECTOMY OR GINGIVOPLASTY - PER TOOTH	39.00
4220	GINGIVAL CURETTAGE, SURGICAL, PER QUAD, BY REPORT	43.00
4240	GINGIVAL FLAP PROCEDURE INC ROOT PLANING/QUAD	105.00
4260	OSSEOUS SURGERY INC FLAP ENTRY/CLOSURE/QUAD	271.00
4261	BONE REPL. GRAFT - SINGLE SITE (INCL FLAP ENTRY/CLS)D2	290.00
4262	BONE REPL. GRAFT - MULT. SITES (INCL FLAP ENTRY/CLS)D2	290.00
4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	19.00
4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	105.00
4271	FREE SOFT TISSUE GRAFT PROC (INCL DONOR SITE SURG)	105.00
4340	PERIO SCALING AND ROOT PLANING	0
4341	PERIO SCALING AND ROOT PLANING - PER QUADRANT	57.00
4910	PERIO MAINTENANCE PROC FOLLOWING ACTIVE THERAPY	34.00

OTHER SERVICES

9220	GENERAL ANESTHESIA - FIRST 30 MINUTES	49.00
9240	INTRAVENOUS SEDATION	20.00

CLASS III

MAJOR RESTORATIVE

2710	CROWN - RESIN - LABORATORY	95.00
2720	CROWN - RESIN WITH HIGH NOBLE METAL	190.00
2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	171.00
2722	CROWN - RESIN WITH NOBLE METAL	200.00
2740	CROWN - PORCELAIN / CERAMIC SUBSTRATE	204.00
2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	219.00
2751	CROWN - PORC FUSED TO PREDOMINANTLY BASE METAL	209.00
2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	209.00
2790	CROWN - FULL CAST HIGH NOBLE METAL	214.00
2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	204.00

MAJOR RESTORATIVE (CONTINUED)		
2792	CROWN - FULL CAST NOBLE METAL	204.00
2810	CROWN - 3/4 CAST METALLIC	209.00
2910	RECEMENT INLAY	15.00
2920	RECEMENT CROWN	15.00
2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	48.00
2950	CORE BUILD-UP, INCLUDING ANY PINS	43.00
2951	PIN RETENTION / TOOTH, IN ADDITION TO RESTORATION	11.00
2952	CAST POST AND CORE IN ADDITION TO CROWN	57.00
PROSTHODONTICS		
1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL	24.00
1525	SPACE MAINTAINER - REMOVABLE - BILATERAL	48.00
5110	COMPLETE DENTURE - MAXILLARY	214.00
5120	COMPLETE DENTURE - MANDIBULAR	214.00
5211	MAXILLARY PART DENTURE - RESIN BASE (CLASP/RESTS)	105.00
5212	MANDIBULAR PART DENTURE - RESIN BASE (CLASP/RESTS)	105.00
5213	MAXILLARY PART DENTURE - METAL FRAME W/RESIN BASE	124.00
5214	MANDIBULAR PART DENTURE - METAL FRAME W/RESIN BASE	124.00
5410	ADJUST COMPLETE DENTURE - MAXILLARY	11.00
5411	ADJUST COMPLETE DENTURE - MANDIBULAR	11.00
5421	ADJUST PARTIAL DENTURE - MAXILLARY	11.00
5422	ADULT PARTIAL DENTURE - MANDIBULAR	11.00
5510	REPAIR BROKEN COMPLETE DENTURE BASE	19.00
5520	REPLACE MISS/BRKN TEETH - COMPLETE DENTURE/TOOTH	19.00
5610	REPAIR RESIN DENTURE BASE	19.00
5620	REPAIR CAST FRAMEWORK, PARTIAL DENTURE	29.00
5630	REPAIR OR REPLACE BROKEN CLASP, PARTIAL DENTURE	13.00
5640	REPLACE BROKEN TEETH - PER TOOTH, PARTIAL DENTURE	21.00
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	61.00
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	38.00
5710	REBASE COMPLETE MAXILLARY DENTURE	40.00
5711	REBASE COMPLETE MANDIBULAR DENTURE	40.00
5720	REBASE MAXILLARY PARTIAL DENTURE	40.00
5721	REBASE MANDIBULAR PARTIAL DENTURE	40.00
5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	49.00
5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	49.00
5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	49.00
5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	49.00
5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	73.00
5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	73.00
5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	73.00
5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	73.00
5850	TISSUE CONDITIONING, MAXILLARY	23.00
FIXED BRIDGE		
1510	SPACE MAINTAINER - FIXED - UNILATERAL	48.00
1515	SPACE MAINTAINER - FIXED - BILATERAL	106.00
6210	PONTIC - CAST HIGH NOBLE METAL	173.00
6211	PONTIC - CAST PREDOMINANTLY BASE METAL	173.00
6212	PONTIC - CAST NOBLE METAL	173.00
6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	185.00
6241	PONTIC - PORCELAIN FUSED TO PREDOM. BASE METAL	181.00
6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	181.00

FIXED BRIDGE (CONTINUED)

6250	PONTIC - RESIN WITH HIGH NOBLE METAL	181.00
6251	PONTIC - RESIN WITH PREDOMINANTLY BASE METAL	143.00
6252	PONTIC - RESIN WITH NOBLE METAL	143.00
6540	RETAINER - ONLAY - METALLIC PER TOOTH (ADD TO INLAY) D2	161.00
6545	RETAINER - CAST METAL - RESIN BONDED FIXED PROSTHESIS	143.00
6720	CROWN - BRIDGE RETAINER - RESIN W/HIGH NOBLE METAL	161.00
6721	CROWN - BRIDGE RETAINER - RESIN PREDOM. BASE METAL	155.00
6722	CROWN - BRIDGE RETAINER - RESIN WITH NOBLE METAL	155.00
6750	CROWN - RETAINER - PORCELAIN FUSED HIGH NOBLE METAL	169.00
6751	CROWN - RETAINER - PORCELAIN FUSED PRED. BASE METAL	159.00
6752	CROWN - RETAINER - PORCELAIN FUSED TO NOBLE METAL	159.00
6780	CROWN - RETAINER 3/4 CAST HIGH NOBLE METAL	161.00
6790	CROWN - RETAINER - FULL CAST HIGH NOBLE METAL	163.00
6791	CROWN - RETAINER - FULL CAST PREDOM. BASE METAL	163.00
6792	CROWN - RETAINER - FULL CAST NOBLE METAL	159.00
6930	RECEMENT FIXED PARTIAL DENTURE	21.00

ORTHODONTIA BENEFIT RIDER:

DEDUCTIBLE, PER INSURED PERSON:	$50 PER CALENDAR YEAR
BENEFIT MAXIMUM, PER INSURED PERSON:	$50 PER MONTH
LIFETIME MAXIMUM, PER INSURED PERSON:	$1,000.00

COVERED EXPENSES - SCHEDULED BENEFIT AMOUNTS

08010	INITIAL CONSULTATION	50% of U&C
08020	DIAGNOSTIC EVALUATION (INCLUDES X-RAYS)	50% of U&C
08030	TREATMENT AND BRACES (UNDER 19 YEARS)	50% of U&C
08210	EACH RETAINER	50% of U&C
08999	MAXILLARY EXPANSION	50% of U&C

DUPLICATE

DEFINITIONS

ADA Code means the American Dental Association Code assigned to a particular dental procedure.

Attained Age means the Insured Person's age on the most recent Certificate anniversary.

Certificate means the written description of coverage provided to You under the Group Policy.

Class Basis means the classification by which each Insured Person's rates are determined. We will not and cannot change the rates on this Certificate unless rates are changed on all Certificates issued on the same Class Basis.

Covered Dependent means an Eligible Dependent whose coverage has become effective under this Certificate and has not terminated.

Covered Expenses means the scheduled benefit amount payable for the services and supplies covered under this Certificate which are incurred by an Insured Person.

Deductible means the Covered Expenses that an Insured Person must pay before the Group Policy pays any benefits. The Deductible is applied against the scheduled benefit amount, not billed charges.

Dentist or Physician means a duly licensed or certified Dentist practicing within the authority of his/her license and a duly licensed or certified Physician authorized by his/her license to perform the particular dental services rendered. A Dentist or Physician does not include You or a member of Your immediate family.

Effective Date of Coverage means the date coverage becomes effective under this Certificate with respect to a particular Insured Person.

Eligible Dependent means Your lawful spouse and Your unmarried natural, adopted and step-children who are under 19 years of age (the Limiting Age). The Limiting Age is extended from the child's 19th birthday to the child's 24th birthday if the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

Group Policyholder means the entity to which the group insurance contract ("Group Policy") is issued.

Insured Person means You or a Covered Dependent under this Certificate.

Waiting Period means the period of time following the Insured Person's Effective Date of Coverage during which no benefits will be payable for expenses incurred. Only Covered Expenses incurred after the end of a Waiting Period will be covered under the Group Policy and used to satisfy the Deductible.

We, Us and Our means Mid-West National Life Insurance Company of Tennessee.

You, Your, Yours means the primary insured named in the Certificate Schedule whose coverage has become effective and has not terminated.

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

Once we have approved Your enrollment application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be on the Certificate Date shown in the CERTIFICATE SCHEDULE.

Additional Dependents

You may add Eligible Dependents by providing evidence of eligibility and insurability satisfactory to Us and upon payment of any additional premium, if required.

The acceptance of a new Eligible Dependent will be shown by endorsement and the date of the endorsement will be the Effective Date of Coverage for the new Eligible Dependent.

PREMIUMS

Premium Due Date

Premiums are payable to Us at our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, semi-annually or annually, as indicated in the CERTIFICATE SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next Premium Due Date, except as provided by the Grace Period. Upon payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

There is a grace period of 31 days for the payment of any premium due, except the first. At the end of the 31 day grace period, We may cancel the Certificate without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period until the premium due is received.

Premium Changes

We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Group Policy at any time and from time to time; provided, We have given the Group Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Certificate may change in amount by reason of an increase in the Attained Age of the Insured Person.

TERMINATION OF COVERAGE

You

Your coverage will terminate and no further benefits will be payable under this Certificate and any attached Riders, if any:

1. At the end of the period for which premium has been paid;
2. At the end of the period through which premium has been paid following Our receipt of Your written request of termination;
3. On the date of fraud or misrepresentation by You;
4. On the date We elect to discontinue this plan or type of coverage;
5. On the date We elect to discontinue all coverage in Your state;
6. On the premium due date following the date You terminate Your membership in the Association to which the Group Policy is issued;
7. On the date an Insured Person is no longer a permanent resident of the United States; or
8. Upon attainment of age 65.

Covered Dependents

Your Covered Dependent's coverage will terminate under this Certificate on:

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date We receive Your written request to terminate a Covered Dependent's coverage.

The attainment of the limiting age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. chiefly dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from you.

We will require that You provide proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the limiting age, and thereafter as We may require such proof not more frequently than annually. In the absence of such proof We may terminate the coverage of such person after the attainment of the limiting age.

Reinstatement

If coverage under this Certificate terminates due to non-payment of premium, We require an application for reinstatement. The reinstatement will not become effective unless We approved such application and receive all premiums then due. We will advise You of the effective date of reinstatement by giving You written notice of the date, by issuing You an amended Certificate or by issuing You a new Certificate. In any case, the reinstated coverage provides benefits only for Covered Expenses incurred after the effective date of reinstatement.

Special Continuation Provision for Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Certificate without evidence of insurability if their coverage under this Certificate would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

1. Divorce, legal separation, Your death; or
2. A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage within 31 days of the date coverage would otherwise terminate, pay any required premium and become a member of the Association to which the Group Policy is issued.

Group Policy

The Group Policyholder may terminate the Group Policy, provided written notice is given to Us at least 31 days prior to the date of termination. The Company may terminate the Group Policy by giving the Group Policyholder at least 31 days written notice prior to the date of termination.

BENEFITS

Covered Expenses

Benefits are payable under this Certificate for the Covered Expenses listed in the CERTIFICATE SCHEDULE that are received by an Insured Person. Unless otherwise stated herein, all benefits are subject to:

1. The Schedule of Benefit Amounts shown in the CERTIFICATE SCHEDULE. If the actual charge is less than the scheduled benefit amount, than the actual charge for the procedure or service will be paid;
2. The Deductible and Benefit Maximums stated in the CERTIFICATE SCHEDULE;
3. Any Waiting Period shown in the CERTIFICATE SCHEDULE;
4. The LIMITATIONS AND EXCLUSIONS; and
5. All other provisions of the Group Policy.

To be a Covered Expense, the dental service must be performed by:

1. a licensed Dentist acting within the scope of his/her license;
2. a licensed Physician performing dental services within the scope of his/her license; or
3. a licensed dental hygienist under the supervision and direction of a Dentist.

Covered Expenses must be incurred while the Insured Person's coverage under this Certificate is in force. A Covered Expense is considered to be incurred on the following dates:

1. Full and partial dentures - on the date the final impression is taken;
2. Fixed bridges, crowns, inlays and onlays - on the date the teeth are first prepared;
3. Root canal therapy - on the date the pulp chamber is opened;
4. Periodontal surgery - on the date surgery is performed;
5. All other services - on the date the service is performed.

Alternate Treatment

If more than one type of service can be used to treat a condition, We have the right to base benefits on the least expensive service which is within the range of professionally adequate standards of dental practice. In the case of bilateral multiple adjacent missing teeth, the benefit amount will be based on a removable partial denture.

LIMITATIONS AND EXCLUSIONS

We will not provide any benefits for any loss caused by or resulting from:

1. Any portion of a charge for any service not listed as a Covered Expense in the CERTIFICATE SCHEDULE;
2. Treatment of disturbances of the temporomandibular joint (TMJ);
3. A service not furnished by a Dentist, unless by a dental hygienist under the dentist's supervision and x-rays ordered by the Dentist;
4. Cosmetic procedures, unless due to an injury or for congenital or developmental malformation. Facing on crowns, or pontics, posterior to the second bicuspid is considered cosmetic;
5. The replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
6. Implants; replacement of lost or stolen appliances; replacement of orthodontic retainers; athletic mouthguards; precision or semi-precision attachments; denture duplication; or splinting;
7. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
8. Replacement of any prosthetic appliance, crown, inlay, or only restoration, or fixed bridge within five (5) years of the date of the last replacement, unless due to an Injury;
9. An initial placement of a partial or full removable denture or fixed bridgework if it involves the replacement of one (1) or more natural teeth lost before covered by the Group Policy. This limitation does not apply if replacement includes a natural tooth extracted while covered under the Group Policy;
10. Services not completed by the end of the month in which coverage terminates;
11. Procedures that are begun, but not completed;
12. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
13. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
14. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
15. Charges that are applied toward the satisfaction of a Deductible, if any;
16. Orthodontic procedures, unless covered by optional benefit rider attached to Your Certificate and in effect; and
17. Covered Expenses for which an Insured Person is not legally obligated to pay.

COORDINATION OF BENEFITS

All of the benefits provided under the Group Policy are subject to this provision.

Plan means any plan providing benefits or services for or by a reason of expenses incurred for hospital, medical, or dental care or treatment, which benefits or services are provided by:

1. group, association group, or blanket insurance coverage;
2. group Blue Cross, Blue Shield or other prepayment coverage provided on a group basis;
3. any coverage under labor-management trustee plans; union welfare plans, self-funded plans, employer organization plans, employee benefit organization plans or any other arrangement of benefits for individuals of a group; any coverage under governmental programs, except Medicaid, and any coverage required or provided by any statute, including no-fault auto insurance.

The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

This Plan refers to provisions of the Group Policy which are subject to this section.

Allowable Expense will be any necessary, Usual and Customary Charge, all or part of which is covered by at least one of the Plans covering the Insured Person. Allowable Expenses to a "secondary" plan will include the value or amount of any deductible amount or co-insurance percentage or amount of otherwise Allowable Expenses which is not paid by the "primary" or first paying plan.

Some plans provide benefits in the form of services rather than cash payments. For those plans, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period is a Calendar Year or portion thereof during which the Insured Person has been covered under This Plan.

Determination of benefits payable under This Plan and all other applicable Plans will be controlled by this provision, if without this provision the sum of the benefits payable under:

1. This Plan; and
2. all other applicable plans,

would exceed the Allowable Expense.

If the sum of 1. and 2. above does exceed the total Allowable Expense, benefits payable under This Plan will be reduced by the amount of benefits payable under all other Plans.

Benefits of any other Plans which contain a COB provision will be ignored when computing the benefits of This Plan if:

1. the other plan's COB provision states that the benefits will be determined after This Plan computes its benefits; and
2. the rules set forth below would require This Plan to compute its benefits first.

DUPLICATE

The rules that set the order of benefit determination are:

1. a plan that covers the Insured Person other than as a dependent will compute benefits before a plan that covers the Insured Person as a dependent; and
2. when a dependent is a child covered under separate plans of each parent, the plan covering the parent whose date of birth (month and day) precedes the other in the Calendar Year shall be primary; except:
   a) where both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; or
   b) where the parents are separated or divorced and the parent with custody of the child has not remarried, then the plan covering the parent with custody shall be primary; or
   c) where the parents are divorced and the parent with custody of the child has remarried; then: (i) the plan covering the parent with custody shall be primary, or (ii) the plan covering the step-parent of the child shall be primary to that of the parent without custody; or
   d) notwithstanding subparagraphs a), b), and c) above, where the parents are divorced or separated and there is a court decree establishing the financial responsibility of medical or other health care expenses with respect to the child of one parent, then the plan covering the parent with the financial responsibility shall be primary; and

3. If benefit determination order is not established above, the primary plan is the plan which has been in effect the longest except:

   a) if plan benefits of the Insured Person are based on a laid-off, or retired employee or a dependent of either, then that plan will be secondary to the other plan's benefits. If neither plan has a provision for a laid-off, or a retired employee or a dependent of either and each plan determines benefits after the other, then this subparagraph a) is not applicable.

We reserve the right to release or obtain information that We deem necessary, about any person to or from:

1. any other insurance company; or
2. any organization or person.

At Our request, the Insured Person shall furnish us with any information needed to determine payment of benefits under this COB provision.

Facility of Payment

Whenever benefits which should have been paid under This Plan are paid under any other Plan, We shall have the right to pay to the organization that made the payments any amount that We feel will satisfy this provision. Amounts so paid will be deemed benefits paid under This Plan and We will be fully discharged from liability under This Plan.

Right of Recovery

If We, at any time, pay the total Allowable Expense and that amount exceeds the payment required to satisfy the intent of this provision, We will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as We shall determine: any persons to or for or with respect to whom such payments were made; any other insurance companies; any other organization.

Time Limit for Payment

Payment of benefits must be made within thirty (30) calendar days after submittal of a proof of loss, unless We provide the claimant a clear and concise statement of a valid reason for further delay which is in no way connected with or caused by the existence of this COB provision nor otherwise attributable to Us.

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

1. the Group Policy, which includes this Certificate;
2. the application of the Group Policyholder, which will be attached to the Group Policy;
3. any enrollment applications for the proposed insured individuals; and
4. any endorsements, amendments or riders attached.

All statements made by the Group Policyholder or by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend the Group Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Group Policy. Any change in the Group Policy will be made by amendment approved by the Group Policyholder and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

Written notice of claim must be given to Us within 20 days, or as soon as reasonably possible. Written notice of claim given by or on behalf of the Insured Person to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms

When We receive the notice of claim, We will send the Insured Person forms for filing proof of loss. If these forms are not furnished within 15 days, the Insured Person will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

Proof of Loss

Written proof of loss must be furnished to Us at Our administrative office in North Richland Hills, Texas within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal capacity, later than one year from the time proof is otherwise required.

Claim Payments

We will pay all benefits due under the Group Policy promptly upon receipt of due proof of loss.

All benefits are payable to You, unless benefits are assigned. If any such benefits remain unpaid at Your death, or if You are, in Our opinion, incapable of giving a legally binding receipt for payment of any benefit, We may, at Our option, pay such benefit to any one or more of the following relatives: Your spouse; mother; father; child or children; brother or brothers; sister or sisters. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

Legal Action

No action at law or in equity will be brought to recover on the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy; nor may any action be brought after expiration of three (3) years after the time written proof of loss is required to be furnished.

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due Us because of past underpayments, will be made so that We receive the premiums due at the correct age payable on the premium due date following Our notification of an age correction.

Incontestability

After two (2) years from the Insured Person's Effective Date of Coverage, no misstatements, except fraudulent misstatements, made in the enrollment application will be used to void the coverage, or deny a claim unless the loss was incurred during the first two (2) years following such Insured Person's Effective Date of Coverage.

Conformity

Any provision of this Certificate which, on the Effective Date of Coverage, is in conflict with the applicable statutes of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

Change of Residence

If You move, You must notify the Company. Only the extraterritorial benefits mandated by the State in which You reside, which are applicable to this type of coverage, will be considered benefits under this Certificate.

Subrogation

You agree that We shall be subrogated to Your right to damages, to the extent of the benefits provided by the Certificate, for injury or sickness that a third party is liable for or causes. You agree to repay Us first out of any monies You obtain regardless of the amount that You recover. In the event that We retain Our own attorney to represent Our subrogation interest, We will not be responsible for paying a portion of Your attorney fees or costs. You assign to Us Your claim against a liable party to the extent of Our payments, and shall not prejudice Our subrogation rights. Entering into a settlement or compromise arrangement with a third party without Our prior written consent shall be deemed to prejudice Our rights. You shall promptly advise Us in writing whenever a claim against another party is made and shall further provide to Us such additional information as is reasonably requested by Us. You agree to fully cooperate in protecting Our rights against a third party.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

ORTHODONTIA BENEFIT RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider are subject to the Deductible, benefit and lifetime maximums shown for this Rider in the CERTIFICATE SCHEDULE and may or may not be considered Covered Expenses under the Certificate.

Benefits under this Rider are available only to Insured Persons under the age of 19. Benefits under this Rider are subject to a 12-month Waiting Period. An Insured Person's coverage under this Rider must be in effect for 12 months before orthodontia services begin in order for coverage under this Rider to be provided.

COVERED EXPENSES

After the Deductible, We will pay benefits for Covered Expenses of an Insured Person under age 19, while this Rider is in force, for the Usual and Customary Charges for the following dental services, up to the benefit and lifetime maximums shown for this Rider in the CERTIFICATE SCHEDULE:

Code	
08010	Initial Consultation
08020	Diagnostic Evaluation (includes x-rays)
08030	Treatment and Braces (under 19 years)
08210	Each Retainer
08999	Maxillary Expansion

DEFINITIONS

Usual and Customary Charges ("U&C") means the charge which is the smallest of:

1. The actual charge;
2. The charge usually made for the Covered Expense by the provider who furnishes it;
3. The prevailing charge made for a Covered Expense in a geographical area by those of similar professional standing.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

SECRETARY

PRESIDENT

DUPLICATE

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE
Oklahoma City, Oklahoma 73118

Administrative Office
9151 Grapevine Hwy.
North Richland Hills, Texas 76180

VISION INSURANCE CERTIFICATE

This Certificate describes the principal provisions of the Group Policy which as issued to the Group Policyholder constitutes the agreement under which benefits are payable. This Certificate replaces all Certificates of Insurance that may have been issued previously under the Group Policy.

RIGHT TO EXAMINE CERTIFICATE
Please read this Certificate. It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this Coverage will meet Your insurance needs, You may return this Certificate to Us at Our Administrative Office within 10 days after You receive it and You will receive a full refund of all premiums You have paid. Then coverage will be considered to be void from its beginning.

IMPORTANT NOTICE
Payment of these benefits is subject to the definitions, conditions, limitations and provisions of the Group Policy and the Certificate. Check the attached enrollment application carefully. If it is not complete or contains an error, please let Us know. An incorrect application may cause Your coverage to be voided, or a claim to be reduced or denied.

This Certificate provides limited vision benefits only.
Please read it carefully.

Please call 1-800-334-7591 if You have inquiries or complaints regarding the coverage provided by this Certificate.

DUPLICATE

TABLE OF CONTENTS

INDEX

SCHEDULE OF BENEFITS

COVERAGES	NETWORK	NON-NETWORK
Vision Exam/Analysis (Limit of one during any one 12 consecutive month period.)		
- Benefit Payment Rate	100%	100% up to $30.00
- Deductible	$0.00	$0.00

CALL 800-334-7591 FOR THE LOCATION OF THE CLOSEST NETWORK PROVIDER.

Covered Member: FRED PLAMBECK

Covered Dependents: SUSAN MEGAN

Initial Premium:	$7.00		
Certificate Date:	06/21/2005	Mode of Payment:	MONTHLY
Certificate Number:	414375799	Renewal Premium:	$7.00
Group Policyholder:	Alliance for Affordable Services		
Group Policy No.:	00181		

DEFINITIONS

Covered Dependent - An Eligible Dependent of a Covered Employee\Member whose coverage has become effective and has not terminated.

Covered Employee\Member - Means an employee or member of the Group Policyholder whose coverage under this plan is effective and has not terminated.

Covered Expenses - Charges for the procedures and supplies specified herein which are incurred by or on behalf of an Insured Person. They are incurred on the date the service is performed or the supply is furnished. Covered Expenses must be incurred while this coverage is in force.

Doctor - A physician; a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, including an optometrist or ophthalmologist or optician. (A member of the Insured Person's immediate family will not be considered a Doctor.)

Eligible Dependent - A Covered Employee\Member's lawful spouse, and unmarried natural children, including unmarried legally adopted children, step-children and any foster children, who are under 19 years of age (the Limiting Age) and living with in the Covered Employee/Member's home. the Limiting Age is extended to age 24 so long as the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

Insured Person - A Covered Employee/Member or a Covered Dependent under this Certificate.

Network Provider - Means an optometrist, ophthalmologist, optician or optical supply business that has contracted with Cole Vision Corporation and has agreed to provide vision care services and supplies as described by that contract to Insured Persons under this plan.

Non-Network Provider - An optometrist, ophthalmologist, optician or optical supply business that has not contracted with Cole Vision Corporation to provide vision care services or supplies to Insured Persons at discounted rates.

We, Our or Us - The Company named in the Group Policy and Certificate as the insurer.

You, Your, Yours - The employee\member named in the Certificate and on the plan identification card whose coverage has become effective and has not terminated.

DUPLICATE

VISION EXPENSE BENEFITS

Benefits for Insured Persons are provided under this Group Policy for the Vision Care services and supplies shown in the Schedule of Benefits. Payment of benefits for any such service or supply will be made in accordance with the specified Benefit Payment Rate and any Deductible Amounts.

Benefit Payment Rate

The Benefit Payment Rate for services and supplies are shown in the Schedule of Benefits. It is the maximum amount of Covered Expenses We will pay for each occurrence or purchase of a supply or service. Any Deductible Amounts will be applied first and then the Benefit Payment Rate will be applied.

Deductible Amount

The Deductible Amount, if any, for a service or supply shown in the Schedule of Benefits will be deducted from Covered Expenses before benefits are paid and will apply separately to each occurrence or purchase of a supply or service.

Covered Expenses

Covered Expenses are the charges made for covered services and supplies listed in the Schedule of Benefits. The maximum benefit amount payable is shown next to each one. Charges must be incurred due to visual defect, injury or disease and must be performed or authorized by a Doctor.

Covered Expenses include the following:

> Vision Analysis - an exam conducted when screening indicates a problem exists or actual symptoms of disease exist. It includes: case history; exam for pathology or anomaly; job vision analysis; refraction; visual field charting; and prescription for lenses. Analysis is provided once every 12 months based on the last analysis date.

Network Provider Services

Network Provider services and supplies are available to all Insured Persons through any participating Network Location. A toll-free telephone number shown in the Schedule of Benefits provides Insured Persons with the location of the closest Network Provider.

Should an Insured Person use the services or supplies of a Network Provider, the Network Benefit Payment Rate shown in the Schedule of Benefits will apply.

Should an Insured Person use the services or supplies of a Non-Network Provider, the Non-Network Benefit Payment Rate shown in the Schedule of Benefits will apply.

If the closest Network Provider is more than 50 miles away from the Insured Person's home, the Benefit Payment Rate shown in the Schedule of Benefits for Non-Network Providers will apply.

Exclusions

We will not provide payment for expenses incurred for or on account of:

1. vision care services, supplies or treatment except as specifically provided for herein; or
2. more than one vision exam/analysis each 12 months; or
3. eye exams as condition of employment, which the employer is required to provide by a labor agreement; or
4. services or materials for which an Insured Person may be paid under employment for wage or profit, unless the Insured Person is not covered under Worker's Compensation or any other occupational disease, employers' liability or similar laws; or

5. any services, supplies or treatment covered under any federal, state, or any other governmental plan or law, except Medicaid; or
6. any services, supplies or treatment for which no charge is normally made in the absence of insurance except Medicaid.

EFFECTIVE DATE OF COVERAGE

Eligibility of Coverage - Any employee or member of the Group Policyholder in an eligible class of employees/members as determined by the Group Policyholder is eligible to apply for coverage under this plan. Any eligible employee or member applying for coverage under this plan may also elect to apply for coverage of all Eligible Dependents, provided the plan allows for Dependent coverage.

Beginning of Coverage - Coverage for eligible Employees/Members and those eligible dependents listed will begin on the first day of the month following receipt of enrollment after the Group Policy effective date.

We will have the right to approve enrollment of any eligible person who does not apply: (1) during the first enrollment period; or (2) within 31 days after first becoming eligible. We may ask for proof of insurability before coverage becomes effective.

Additions or Changes to Coverage - Additions or changes to existing coverage will require Our approval. If approved, the change in coverage will take effect the first day of the month following approval.

Newborn Children - Newborn Children born after the effective date of this Group Policy will be provided coverage from the moment of birth for 31 days. To continue coverage beyond 31 days, written notice must be sent directing Us to add the newborn child. This notice must be received by Us within 31 days of the newborn child's birth and must be accompanied by any required additional premium.

Additional Dependents - Additional dependents may be added by providing evidence of eligibility satisfactory to Us and upon payment of the premium required for such additional dependents. If approved, the change will take effect the first day of the month following approval.

PREMIUMS

Premiums/Due Date - Premiums are based on the rate table in effect on each premium due date. They are payable to the Company at its Administrative Office. The premium is payable monthly, quarterly, semi-annually or annually. The Company may discontinue a mode of premium payment on any premium Due Date. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period.

Grace Period - A Grace Period of 31 days, measured from the premium Due Date, will be allowed for payment of all premiums due, other than the first. During this Grace Period, the coverage will remain in force. However, the Grace Period and coverage thereunder will not apply if We receive written notice from the Group Policyholder that coverage is to be terminated or termination of coverage is due to events other than failure to pay premium, as provided below.

Premium Changes - We will not change renewal premiums payable on account of any Insured Person's physical condition or on account of any claims paid. However, unless otherwise provided in the Schedule of Benefits, We reserve the right to change the table of premiums, on a class basis, becoming due under the Group Policy, at any time and from time to time; provided, We have given the Group Policyholder written notice of at least 60 days prior to the effective date of the new rates.

TERMINATION OF COVERAGE

Covered Employee/Members - Coverage for Covered Employees/Members will terminate on and no benefits will be payable on or after: written notice of cancellation to Us; the premium due date on which the premium due is not paid, subject to the Grace Period provision; the date the Group Policy terminates or the date all employees\members of the class of insured terminates; the date he or she ceases to be a employee/member in good standing of the Group Policyholder.

A Covered Employee/Member may terminate coverage and that of any Covered Dependent(s) by providing Us or the Group Policyholder with written notice of cancellation. Employee/Member Coverage and/or that of any Covered Dependent(s) will terminate on the last day of the month for which premium is paid.

Covered Dependents - Covered Dependent's coverage will terminate on: the date the Covered Employee/Member's coverage terminates; the date such dependent ceases to be an Eligible Dependent; or the date the Group Policy terminates.

If a Covered Dependent child who has been continued beyond the Limiting Age as a full-time student ceases to be a full-time student, Our liability under the Group Policy and Certificate will be limited to a refund of premium from the date the child ceased to be a full-time student.

IThe attainment of the Limiting Age for a Covered Dependent will not cause coverage to terminate while that person is and continues to be both: (a) incapable of self-sustaining employment by reason of mental or physical handicap; and (b) Chiefly Dependent on the Covered Employee/Member for support and maintenance. Chiefly Dependent means the Covered Dependent receives the majority of his/her financial support from the Covered Employee/Member. We will require proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the Limiting Age and, thereafter, We may require such proof not more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the Limiting Age.

If We accept a premium for any period beyond the date coverage would end, coverage will continue in force during the period for which premium was paid.

Group Policy - The Group Policyholder or the Company may terminate the Group Policy, provided written notice is given to the other party at least 60 days prior to the date of termination.

The Company may terminate the Group Policy on any premium due date when eligible Employee/Member and/or Dependent participation is less than the participation amounts selected in the Application for Vision Insurance of the Group Policyholder.

GENERAL PROVISIONS

Entire Contract - The Entire Contract will consist of: the Group Policy; the application of the Group Policyholder which will be attached to the Group Policy; enrollment applications or reinstatement applications for the proposed Insured Persons, if any; and endorsements or amendments issued with or added to the Group Policy.

All statements made by the Group Policyholder or by any Insured Persons will, in the absence of fraud, be deemed representations and not warranties.

Only the president, a vice president, or a secretary of the Company has the power on behalf of the Company to execute or amend the Group Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Group Policy or Summary Plan Description. Any change in the Group Policy will be made by amendment approved by the Group Policyholder and signed by the Company. Such amendment will not require the consent of any Insured Person. We may issue an Endorsement or new Group Policy to reflect such amendment.

Summary Benefit Description - We will issue a Summary Benefit Description to all Covered Employees/Members. The Summary Benefit Description summarizes the rights and benefits of Insured Persons under the Group Policy. The Summary Benefit Description does not constitute a part of the Group Policy and does not change any of the conditions and provisions of the Group Policy.

Notice of Claim - Written notice of claim must be given to the Company or its benefit administrator as soon as possible for Non-Network Provider claims. Written notice of claim given by or on behalf of an Insured Person with information sufficient to identify such person will be considered notice. Notice of claim is not required for Network Provider Claims.

Claim Forms - When the Company or its benefit administrator receives the notice of claim, it will send the Covered Employee/Member forms for filing proof of loss. If these forms are not furnished within 15 days (10 days in Georgia), the Insured Person will meet the proof of loss requirements by giving a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof of Loss - Written proof of loss must be furnished to the Company or its benefit administrator within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Claim Payments - We will pay all benefits due under the Group Policy promptly upon receipt of due proof of loss. All benefits are payable to the Covered Employee/Member or a designated beneficiary on file with Us. However, at Our option We may pay the provider of service instead, unless requested otherwise in writing prior to providing proof of loss. If any such benefits remain unpaid at the Covered Employee/Member's death, or if the Covered Employee/Member is, in the opinion of the Company, incapable of giving a legally binding receipt for payment of any benefit We may, at Our option, pay such benefit to any one or more of the following relatives: the Covered Employee/Member's spouse; mother; father; child or children; brother or brothers; sister or sisters. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

Legal Action - No action at law or equity will be brought to recover on the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy; nor will any action be brought after expiration of 3 years (2 years in Maine; 6 years in South Carolina) after the time written proof of loss is required to be furnished.

Incontestability - After two years from the effective date of any Insured Person's coverage or reinstated coverage, no misstatements, except fraudulent misstatements, made in the enrollment application or reinstatement application for that Insured Person will be used to void coverage of an Insured Person or to deny a claim for loss incurred which commences after the expiration of such two year period.

No claim for a loss incurred two years after the effective date of an Insured Person's coverage or reinstated coverage will be reduced or denied unless excluded by name or specific description.

Reinstatement - If any renewal premium is not paid within the grace period, the Group Policy will terminate.

Automatic reinstatement may occur up to 60 days from termination if the Company accepts payment of all renewal or back premiums.

Reinstatement more than 60 days from termination requires Company approval and/or application, as well as payment of all renewal or back premiums.

The reinstated policy shall only cover loss resulting more than ten (10) days after such date. In all other respects, the Insured Person and the Company shall have the same rights as the Insured Person had under this Group Policy before the date of defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

An agent of the Company does not have the authority to accept reinstatement premiums.

Conformity - Any provision of the Group Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Group Policyholder resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Signed for Mid-West National Life Insurance Company of Tennessee at North Richland Hills, Texas.

Secretary

President

Mid-West National Life Insurance Company of Tennessee
Claims Department

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
Article #: 7003 1680 0001 3222 7057

February 6, 2006

Fred Plambeck
28869 Pioneer Grove
Cary IL 60013

Re: Certificate Number: 02404375799 Health
02414375799 Vision
02444375799 Dental
Insured/Patient: Susan Plambeck

Dear Mr. Plambeck:

7003 1680 0001 3222 7057

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
OFFICIAL USE
Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $
Postmark Here
Sent To
Street, Apt. No.; or PO Box No.
City, State, ZIP+4
PS Form 3800, June 2002 See Reverse for Instructio

Our investigation in connection with Susan's pending claims is now complete. With consent, we requested and received medical records from your medical service providers. These records document treatment for bulging discs at L2-3, L4-5, and L5-S1 prior to the effective date.

The Certificate of Insurance issued to Fred Plambeck, effective June 21, 2005, was individually underwritten and contains a contestable period of two years. The incontestability provision grants the Company the right to void or amend coverage within two years of the effective date in the event material medical history is omitted from the enrollment application.

On the application for this Certificate dated June 15, 2005, medical questions were asked concerning all applicants' past health history. The answers given to the medical questions did not mention the medical history described above. The specific medical questions in your application to which we refer are numbers 17I (back or spine disorders), 18, and 19. Enclosed for your review is a copy of your application which shows the answers to the medical questions. A copy of this same application was attached to and made a part of the Certificate that was delivered to you.

The answers which were given induced us to issue coverage, and we relied on the answers to the medical questions asked on the application, as they were material to the acceptance of the risk being assumed. Had our Underwriting Department been aware of the previous medical history the Certificate would have only been issued with the following Administrative Endorsement:

For Susan Plambeck—The Certificate Shall Not Cover Nor Shall Any Indemnity Be Payable For Care Or Confinement For, Or Charges For Treatment Of, Injury To Or Disorder Of The Thoracic Spine, Its Muscles, Ligaments, Discs, Or Nerve Roots, And Any Complications Thereof.

For Susan Plambeck—The Certificate Shall Not Cover Nor Shall Any Indemnity Be Payable For Any Disease, Disorder, Or Injury Of The Lumbar Spine Or Its Nerve Roots, Ligaments, Or Muscles And/Or Complications Thereof.

EXHIBIT C

5173006000320403

Attached are two (2) original copies of the Administrative Endorsement that is being added to the Certificate. You should return one (1) original to this office in the enclosed envelope after the document has been signed and dated. The other copy should be attached to your Certificate of Insurance. Addition of the Administrative Endorsement is retroactive to the effective date of coverage of June 21, 2005.

We must have the signed Administrative Endorsement by no later than February 27, 2006, or we will assume that you do not accept addition of the Endorsement, at which time we will rescind all coverage. If coverage is rescinded, our obligation will be limited to refunding the premiums received by us since coverage began, less any claims previously paid by us. However, prior to taking that action, we do want to make certain that we have all the facts, and we want to give you the opportunity to provide any information or comments you would like considered. Therefore, we request that you provide answers to the following questions.

1. Was Susan diagnosed with bulging discs at L2-3, L4-5, and L5-S1 on February 4, 2005 and February 7, 2005 as indicated by the records received?
   Yes ( ) No ( )

2. Are questions 17l (back and spine disorders), 18, and 19 on the enclosed copy of your application, answered correctly?
   Yes ( ) No ( )

3. Please explain in detail why the above medical history was omitted from your enrollment application.

   _____

   _____

   _____

As noted previously, we do want to make certain that we have all the facts, and we want to give you the opportunity to provide any information or comments you would like considered.

6173006000026941

However, if we do not receive additional information from you nor the signed Administrative Endorsement by February 27, 2006 we will have no alternative but to proceed with rescission of the entire Certificate of Insurance. We look forward to receiving the signed Administrative Endorsement so that coverage is not interrupted. If you have any questions regarding this matter, please contact me at 1-800-527-2845, extension 8606.

Sincerely,

Elizabeth Hargrove
Special Investigations Unit
Mid-West National Life Insurance Company of Tennessee

Enclosure

Midwest National Life Insurance Co. of Tennessee

9151 Boulevard 26
P. O. Box 982017
North Richland Hills, Texas 76182-8017

617306000202

ENDORSEMENT

Attached to and made a part of Policy/Certificate No.

In consideration of issuance, the Policy/Certificate is hereby amended and modified as follows:

For Susan Plambeck----The Certificate Shall Not Cover Nor Shall Any Indemnity Be Payable For Care Or Confinement For, Or Charges For Treatment Of, Injury To Or Disorder Of The Thoracic Spine, Its Muscles, Ligaments, Discs, Or Nerve Roots, And Any Complications Thereof.

For Susan Plambeck----The Certificate Shall Not Cover Nor Shall Any Indemnity Be Payable For Any Disease, Disorder, Or Injury Of The Lumbar Spine Or Its Nerve Roots, Ligaments, Or Muscles And/Or Complications Thereof.

Anything in said Policy/Certificate to the contrary notwithstanding. This Endorsement is effective on the Effective Date of the Policy/Certificate and shall expire concurrently with said Policy/Certificate unless otherwise terminated.

In Witness Whereof, Midwest National Life Insurance Co. of Tennessee has issued this Amendment to the Policy/Certificate.

APPLICANT SIGNATURE (if required) DATE

Secretary

5173065000203B
6051002000900I03

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to: SIU

Fred Plambeck
28869 Pioneer Grove
Cary IL 60013

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

CARY IL 60013 USPS

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7003 1680 0001 3222 7057

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

024643751799

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE
CLAIM DEPARTMENT

617306000021

April 24, 2006

Fred Plambeck
28869 Pioneer Grove
Cary, IL 60013

Re: 02404375799
Susan Plambeck

Dear Sir:

I have received your request for a copy of Susan's medical records. Attached you will find an authorization, required by law, prior to release of those records. The letter indicates a $25.00 fee is required but that has been waived. The letter must be notarized. You may fax the letter to me at 817-255-8104.

If I can be of further assistance, please contact me at 800-527-2845 extension 8606.

Sincerely,

Elizabeth Hargrove
Special Investigations Unit

EXHIBIT D

HealthMarkets
Keeping the Promise of Affordable Coverage
Administrative Services Group

617306500002022

ACCESS REQUEST

Use this form for requests to obtain copies of an individual's PHI or records in company record sets.

SECTION A: Individual requesting access.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Health ID Number: _____

SECTION B: To the Individual—Please read the following and complete the information requested.

You have the right to inspect and obtain copies of your PHI maintained by company business associates except for:

- psychotherapy notes compiled for use in any civil, criminal or administrative action or proceeding; or
- information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a).

To exercise your right of access, please complete Section B and have your request notarized.

Please specify the copies of records you wish to obtain:

_____

_____

All record copies will be billed at $25 for the first 50 pages then $0.25 per page thereafter. All records will be mailed certified.

**********this fee has been waived**********

If you wish to provide access to or copies of your records to any person other than you or your personal representative, you must provide a signed authorization (appropriate authorization form is available from the company).

_____ _____

_____ _____

SIGNATURE.

_____ Date: _____

If this request is by an IPR on behalf of the individual, complete the following:

Individual Personal Representative's Name: _____

Relationship to Individual: _____

By: _____ _____
Date

617300600202023

State of: _____

County of: _____

Subscribed and sworn to before me this _____ day of _____.

Notary Public: _____

Print Name _____

My commission expires: _____.

SECTION C: Response to Access Request—To be completed by Privacy Official/designee.

Access denied on ____/____/____ by transmittal of Denial of Access to Records to the individual.

☐ Individual requested review of licensed professional's determination on ____/____/____. Attach sheet explaining disposition.

☐ Individual lodged complaint on ____/____/____. See Form 12(c)-COMPLAINT for nature of complaint and its disposition.

Access granted on ____/____/____ by transmittal of Grant of Access to Records to the individual.

☐ Copies supplied: ____/____/____ Charges: $_____ Paid: ____/____/____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Mid-West National Life Insurance Company of Tennessee
Home Office: Oklahoma City, OK

9151 Boulevard 26
PO Box 982017
North Richland Hills, TX 76182

Phone: 800-733-8880
Fax: 817-255-8104

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE
Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $
Postmark Here
Sent To
Street, Apt. No.; or PO Box No.
City, State, ZIP+4
PS Form 3800, June 2002
See Reverse for Instructions
7005 0390 0005 1344 2179

Certified Mail 7005 0390 0005 1344 2179

April 26, 2006

Fred Plambeck
28869 Pioneer Grove
Cary, IL 60013

Re: Certificate Number: 02404375799 – Health
02414375799 – Vision
02444375799 – Dental
Insured: Fred Plambeck
Patient: Susan Plambeck

Thank you for your response to our correspondence dated February 6, 2006. Your letter prompted me to send a letter to Dr. Diorio. A copy was also sent to you. Dr. Diorio has responded and has indicated that you were aware of the MRI results on the thoracic spine that include an impression of mild anterior spurring and disk bulging in the mid-to-lower thoracic region anteriorly consistent with mild degenerative arthritic change. They also include results for the MRI of the lumbar spine with an impression of mild posterior disc bulging at the L2-3 level. At the L4-5 level there is evidence of slight posterior disc bulging. At the L5-S1 level there is mild posterior disc bulging, most pronounced centrally. There is also minimal spurring of the postero-inferior corners of the L4 and L5 vertebral bodies. No significant central canal stenosis is seen.

Your letter also requested a copy of the medical records. However, due to the Health Information Portability and Accountability Act of 1996 (HIPAA) that governs privacy and security of health information, we can provide those to you but are required to receive a signed release authorizing us to do so. I sent that to you in a letter dated April 24, 2006 and waived the standard $25.00 fee. Upon receipt of that signed and notarized authorization, records will be forwarded to you.

The July 15, 2005, enrollment application, a copy of which is enclosed, states in part:

"I agree that: (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; .... "

By signing the enrollment application, you endorsed the information contained within the application. Additionally, by signing the application, you agreed to the terms upon which coverage, if any, would be issued. In addition to the enrollment application, you signed the Confirmation of Presentation and Conditional Receipt, which states in part:

"I fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to refuse coverage and to refund all my premium as though my coverage had never been in force."

As our previous correspondence written February 6, 2006 indicated, based on your diagnosis of bulging discs at L2-L3, L4-L5, and L5-S1 coverage would have been issued with an administrative endorsements. Omission of this material medical history deprived us the opportunity to properly underwrite coverage and the risk being assumed. A valid contract has not existed.

At this time you have the following options:

1. Sign and return the enclosed Administrative Endorsements excluding coverage on you for any disease, disorder or injury of the thoracic spine, its muscles, ligaments discs, or nerve roots and any disease, disorder or injury of the lumbar spine, its nerve roots, ligaments or muscles.

2. If you do not wish to accept the above option, please sign and date the enclosed Agreement of Rescission and General Release, in the presence of a Notary Public. Upon our receipt, all premiums received by us since coverage began, less any claims paid by us, will be refunded to you and the certificate insurance will be voided as of the effective date of June 21, 2005.

Please provide your response to the above options by May 10, 2006. If you have any questions regarding this matter, please contact me at 1-800-527-2845, extension 8606.

Sincerely,

Elizabeth Hargrove
Special Investigations Unit
Mid-West National Life Insurance Company of Tennessee

Enclosure

617300600002029

Midwest National Life Insurance Co. of Tennessee

9151 Boulevard 26
P. O. Box 982017
North Richland Hills, Texas 76182-8017

ENDORSEMENT

Attached to and made a part of Policy/Certificate No.

In consideration of issuance, the Policy/Certificate is hereby amended and modified as follows:

For Susan Plambeck—The Certificate Shall Not Cover Nor Shall Any Indemnity Be Payable For Care Or Confinement For, Or Charges For Treatment Of, Injury To Or Disorder Of The Thoracic Spine, Its Muscles, Ligaments, Discs, Or Nerve Roots, And Any Complications Thereof.

For Susan Plambeck----The Certificate Shall Not Cover Nor Shall Any Indemnity Be Payable For Any Disease, Disorder, Or Injury Of The Lumbar Spine Or Its Nerve Roots, Ligaments, Or Muscles And/Or Complications Thereof.

Anything in said Policy/Certificate to the contrary notwithstanding. This Endorsement is effective on the Effective Date of the Policy/Certificate and shall expire concurrently with said Policy/Certificate unless otherwise terminated.

In Witness Whereof, **Midwest National Life Insurance Co. of Tennessee** has issued this Amendment to the Policy/Certificate.

APPLICANT SIGNATURE (if required) DATE

Secretary

617306030002030

AGREEMENT OF RESCISSION AND GENERAL RELEASE

Fred Plambeck, for himself, his heirs, executors, personal representatives and assigns, for and in consideration of the sum of $5,264.39 to be paid to him by The Midwest National Life Insurance Company of Tennessee ("Mid-West"), the receipt and sufficiency of which is hereby acknowledged, does hereby agree that the insurance coverage represented by Certificate No. 02404375799, 02414375799 and 02444375799, issued by Mid-West effective 06-01-05 is rescinded, void, and of no effect whatsoever as of its initial effective date, and Fred Plambeck does hereby forever release, acquit and discharge Mid-West and all of its present and former officers, directors, employees, agents, predecessors and successors from all claims, liabilities, losses, demands, damages, actions and causes of action which have arisen or may arise, known and unknown, that relate to, arise out of, or are based upon acts, events, occurrences, conduct or transactions that have taken place up to and including the date of Fred Plambeck's execution of this Release.

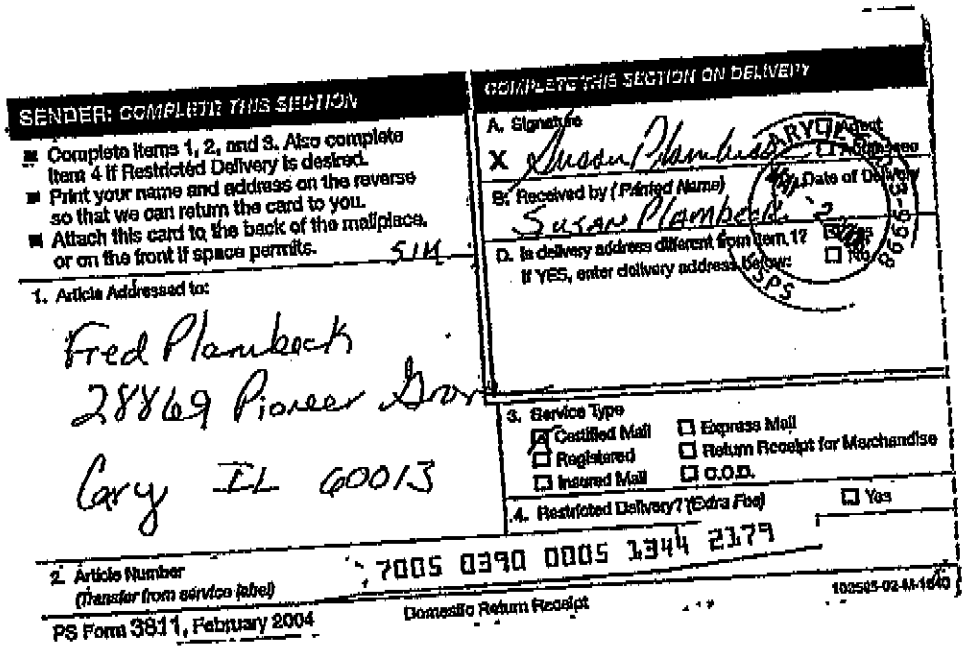
In making this Release, Fred Plambeck agrees that the payment by Mid-West acknowledged hereby is made by Mid-West without admission of liability in settlement of a doubtful and disputed claim, all liability being expressly disclaimed by Mid-West; and further, that this is a full, binding and final release between himself and the released parties, and that in executing this Release, he has not relied upon any oral representations of Mid-West or anyone purporting to act on its behalf, and that he has exercised his own independent judgment, belief and knowledge.

_____
Fred Plambeck

STATE OF ILLINOIS
COUNTY OF _____

BEFORE ME, the undersigned authority, on the ____day of _____, 2006, personally appeared Fred Plambeck, who is personally known or was satisfactorily identified to me, and who acknowledged that he subscribed the above and foregoing instrument as his voluntary act and deed for the purposes expressed therein.

_____
NOTARY PUBLIC State of Illinois
My Commission expires:_____



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Fred Plambeck
28869 Pioneer Dr
Cary IL 60013

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Susan Plambeck — Agent — Addressee

B. Received by (Printed Name) Susan Plambeck — C. Date of Delivery

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7005 0390 0005 1344 2179

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Mid-West National
Life Insurance
Company of Tennessee
Home Office: Oklahoma City, OK

MID-WEST

9151 Boulevard 26
PO Box 982017
North Richland Hills, TX 76182

Phone: 800-733-8880
Fax: 817-255-8104

617300600022003

June 21, 2006

Fred Plambeck
28869 Pioneer Grove
Cary, IL 60013

RE: Certificate #: 02404375799, 02414375799, 02444375799

Dear Mr. Plambeck:

We have previously sent correspondence to you on April 26, 2006 notifying you of our intent to decline your coverage due to Susan's medical history of mild anterior spurring and disk bulging in the mid-to-lower thoracic spine. This letter contained an Endorsement to exclude Susan from the policy and an Agreement of Rescission and General Release to terminate coverage.

Since we have not received the signed Endorsement or Release, we are proceeding with the rescission of the certificate. As such, our check # 2000579 in the amount of $552.00 and check # 2000578 in the amount of $840.00 and check # 2000577 in the amount of $5708.62 were sent under separate cover. These checks represent a full refund of all premiums you have paid to us since coverage began, less any claims previously paid.

Coverage under the above Certificate is now void *ab initio*, as of the effective date of June 21, 2005. Consequently, there is no basis for any claim.

Membership dues from the National Associate of the Self-Employed are not affected by the rescission. The dues will continue to draft unless you contact their office directly to request cancellation. Their phone number is 800-232-6273 and reference Certificate #02494375799.

If you have any questions, please contact us at 1-800-733-8880 extension 8606.

Sincerely,

Elizabeth Hargrove
Special Investigations Unit

EXHIBIT F

THE FACE OF THIS DOCUMENT IS PRINTED WITH A COLORED BACKGROUND ON WHITE PAPER

Mid-West National Life Insurance Company of Tennessee
P.O. Box 982010
N. Richland Hills, Texas 76182

No. 2000579

THE BANK OF NEW YORK (DELAWARE)
NEWARK, DELAWARE
52-95
311

PAY EXACTLY ********** Five Hundred Fifty Two Dollars and No Cents **********

CHECK DATE	AMOUNT OF CHECK
06/20/06	$552.00

VOID AFTER 90 DAYS

TO THE ORDER OF
Fred Plambeck
28869 Pioneer Grove
Cary IL 60013

BY: _____ MP
AUTHORIZED REPRESENTATIVE

BY: _____ MP
AUTHORIZED REPRESENTATIVE

⑆2000579⑆ ⑆031100351⑆ ⑆0300914546⑈

Mid-West National Life Insurance Company of Tennessee — Check Number 2000579

DATE	CERTIFICATE NUMBER	PAYEE NAME	NET AMOUNT
6/20/2006	02 444375799	Fred Plambeck	$552.00

evt

READ CAREFULLY! This check is tendered to you as a FULL REFUND of all premiums paid, net of benefits paid, if any. THIS CHECK IS OFFERED TO YOU AS FULL AND FINAL PAYMENT on condition that if you cash or deposit this check, you thereby agree that certificate No. 02 444375799 is null and void, canceled and of no effect, as of its original effective date.

DR-668A

Case 1:08-cv-00366 Document 1-2 Filed 01/16/2008 Page 62 of 73

THIS CHECK MUST BE ENDORSED EXACTLY AS THE NAME(S) OF PAYEE APPEARS ON THE FACE SIDE
READ CAREFULLY THIS CHECK IS TENDERED TO YOU AS A FULL REFUND OF ALL PREMIUMS PAID, NET OF BENEFITS PAID, IF ANY. THIS CHECK IS OFFERED TO YOU AS FULL AND FINAL PAYMENT ON CONDITION THAT IF YOU CASH OR DEPOSIT THIS CHECK, YOU THEREBY AGREE THAT CERTIFICATE NO. D2 4AL395 999 IS NULL AND VOID, CANCELLED AND OF NO EFFECT, AS OF ITS ORIGINAL EFFECTIVE DATE

ENDORSEMENT: _____

DO NOT WRITE, STAMP OR SIGN BELOW THIS LINE
RESERVED FOR FINANCIAL INSTITUTION USE

* FEDERAL RESERVE BOARD OF GOVERNORS REG. CC

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Mid-West National Life Insurance Company of Tennessee
P.O. Box 982010
N. Richland Hills, Texas 76182

No. 2000578

THE BANK OF NEW YORK (DELAWARE)
NEWARK, DELAWARE
62-35
311

PAY EXACTLY **********Eighty Four Dollars and No Cents**********

CHECK DATE	AMOUNT OF CHECK
06/20/06	$84.00

VOID AFTER 90 DAYS

TO THE ORDER OF
Fred Plambeck
28869 Pioneer Grove
Cary IL 60013

BY: [signature] AUTHORIZED REPRESENTATIVE

BY: AUTHORIZED REPRESENTATIVE

⑆2000578⑆ ⑆031100351⑆ ⑆03009145461⑆

Mid-West National Life Insurance Company of Tennessee

Check Number 2000578

DATE	CERTIFICATE NUMBER	PAYEE NAME	NET AMOUNT
6/20/2006	02 414375799	Fred Plambeck	$84.00

evt

READ CAREFULLY! This check is tendered to you as a FULL REFUND of all premiums paid, net of benefits paid, if any. THIS CHECK IS OFFERED TO YOU AS FULL AND FINAL PAYMENT on condition that if you cash or deposit this check, you thereby agree that certificate No. 02 414375799 is null and void, canceled and of no effect, as of its original effective date.

Dist-668A

THIS CHECK MUST BE ENDORSED EXACTLY AS THE NAME(S) OF PAYEE APPEARS ON THE FACE SIDE.
READ CAREFULLY! THIS CHECK IS TENDERED TO YOU AS A FULL REFUND OF ALL PREMIUMS PAID, NET OF BENEFITS PAID, IF ANY. THIS CHECK IS OFFERED TO YOU AS FULL AND FINAL PAYMENT ON CONDITION THAT IF YOU CASH OR DEPOSIT THIS CHECK, YOU THEREBY AGREE THAT CERTIFICATE NO. 02 414 275 194 IS NULL AND VOID, CANCELLED AND OF NO EFFECT, AS OF ITS ORIGINAL EFFECTIVE DATE

ENDORSEMENT: _____

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Mid-West National Life Insurance Company of Tennessee
P.O. Box 982010
N. Richland Hills, Texas 76182

No. 2000577

THE BANK OF NEW YORK (DELAWARE)
NEWARK, DELAWARE
62-35
311

PAY EXACTLY **********Five Thousand Seven Hundred Eight Dollars and Sixty Two Cents**********

CHECK DATE	AMOUNT OF CHECK
06/20/06	$5,708.62

VOID AFTER 90 DAYS

TO THE ORDER OF
Fred Plambeck
28869 Pioneer Grove
Cary, IL 60013

BY: _____ AUTHORIZED REPRESENTATIVE

BY: _____ AUTHORIZED REPRESENTATIVE

⑈2000577⑈ ⑆031100151⑆ ⑆0300914546⑈

Mid-West National Life Insurance Company of Tennessee — Check Number 2000577

DATE	CERTIFICATE NUMBER	PAYEE NAME	NET AMOUNT
6/20/2006	02 404375799	Fred Plambeck	$5,708.62

evt

READ CAREFULLY! This check is tendered to you as a FULL REFUND of all premiums paid, net of benefits paid, if any. THIS CHECK IS OFFERED TO YOU AS FULL AND FINAL PAYMENT on condition that if you cash or deposit this check, you thereby agree that certificate No. 02 404375799 is null and void, canceled and of no effect, as of its original effective date.

THIS CHECK MUST BE ENDORSED EXACTLY AS THE NAME(S) OF PAYEE APPEARS ON THE FACE SIDE
READ CAREFULLY! THIS CHECK IS TENDERED TO YOU AS A FULL REFUND OF ALL PREMIUMS PAID, NET OF BENEFITS PAID, IF ANY. THIS CHECK IS OFFERED TO YOU AS FULL AND FINAL PAYMENT ON CONDITION THAT IF YOU CASH OR DEPOSIT THIS CHECK, YOU THEREBY AGREE THAT CERTIFICATE NO. 02 402 975 749 IS NULL AND VOID, CANCELLED AND OF NO EFFECT, AS OF ITS ORIGINAL EFFECTIVE DATE

ENDORSEMENT:_____

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The security features on this document include Void Pantograph, Padlock, and Security Paper. Absence of these features indicates alteration.

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

FRED PLAMBECK and SUSAN PLAMBECK,	)	FILED B - 20
	)	2007 DEC 19 PM 4: 06
plaintiffs,	)	
	)	
vs.	)	No. **2007 M1 158507**
	)	(Transferred to Law)
MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE,	)	
	)	
defendant.	)	

ANSWER TO AFFIRMATIVE DEFENSES AND COUNTERCOMPLAINT

FRED PLAMBECK and SUSAN PLAMBECK, plaintiffs, answer the affirmative defenses and counterclaim of MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE, and state as follows.

Answer to Affirmative Defenses

First Affirmative Defense

1. Plaintiffs admit the allegations of paragraph 1.
2. Plaintiffs admit the allegations of paragraph 2.
3. Plaintiffs admit the allegations of paragraph 3.
4. Plaintiffs admit the allegations of paragraph 4.
5. Plaintiffs admit the allegations of paragraph 5.
6. Plaintiffs admit the allegations of paragraph 6.
7. Plaintiffs admit the allegations of paragraph 7 insofar as it alleges that certain policies were issued to plaintiffs. Plaintiffs cannot admit or deny any allegations regarding defendant's alleged "reliance" as such information is solely within the knowledge of defendant.
8. Plaintiffs admit the allegations of paragraph 8.
9. Plaintiffs deny the allegations of paragraph 9.

10. Plaintiffs deny the allegations of paragraph 10.

11. Plaintiffs deny the allegations of paragraph 11.

12. Plaintiffs deny the allegations of paragraph 12.

13. Plaintiffs deny the allegations of paragraph 13.

14. Plaintiffs deny the allegations of paragraph 14.

15. Plaintiffs deny the allegations of paragraph 15, except plaintiff admits that Susan sought medical attention for headaches.

16. Plaintiffs cannot admit or deny the allegations of paragraph 16, except plaintiff admits that Susan sought medical attention for headaches.

17. Plaintiffs deny the allegations of paragraph 17.

18. Plaintiffs deny the allegations of paragraph 18.

19. Plaintiffs deny the allegations of paragraph 19.

20. Plaintiffs deny the allegations of paragraph 20.

21. Plaintiffs deny the allegations of paragraph 21.

22. Plaintiffs deny the allegations of paragraph 22.

23. Plaintiffs deny the allegations of paragraph 23.

24. Plaintiffs admit the allegations of paragraph 24.

25. Plaintiffs admit the allegations of paragraph 25.

26. Plaintiffs admit the allegations of paragraph 26, but deny that defendant's request was proper, reasonable, or required under the contract.

27. Plaintiffs admit the allegations of paragraph 27, but deny that defendant's request was proper, reasonable, or required under the contract.

28. Plaintiffs admit the allegations of paragraph 28, but deny that defendant's request was proper, reasonable, or required under the contract.

29. Plaintiffs admit the allegations of paragraph 29, but deny that defendant's request was proper, reasonable, or required under the contract.

30. Plaintiffs deny the allegations of paragraph 30, but deny that defendant's action was proper, reasonable, or allowed under the contract.

31. Plaintiffs deny the allegations of paragraph 31.

Second Affirmative Defense

1. Plaintiffs deny that the second affirmative defense is a defense at all. Rather, it is only a plea alleging set-off or reduction of damages.

2. Plaintiffs deny that the second affirmative defense is a defense at all. Rather, it is only a plea alleging set-off or reduction of damages.

Third Affirmative Defense

1. Plaintiffs admit the allegations of paragraph 1.

2. Plaintiffs deny the allegations of paragraph 2.

Answer to Counterclaim

Plaintiffs answer the counterclaim as follows.

1. Plaintiffs admit the allegations of paragraph 1.

2. Plaintiffs admit the allegations of paragraph 2.

3. Plaintiffs admit the allegations of paragraph 3.

4. Plaintiffs admit the allegations of paragraph 4.

5. Plaintiffs admit the allegations of paragraph 5.

6. Plaintiffs admit the allegations of paragraph 6.

7. Plaintiffs admit the allegations of paragraph 7.

8. Plaintiffs admit the allegations of paragraph 8.

9. Plaintiffs admit the allegations of paragraph 9.

10. Plaintiffs admit the allegations of paragraph 10 insofar as it is alleged that plaintiffs were approved and issued policies of insurance by defendant. However, despites plaintiffs' requests, defendant failed to provide copies of the insurance certificates and policy terms to plaintiffs, thus, plaintiffs can neither admit nor deny that

Exhibit B to the counterclaim is a true and accurate copy of the policies issued to plaintiffs. Plaintiffs deny that the policies were issued in reliance on the representations in the application.

11. Plaintiffs admit the allegations of paragraph 11.

12. Plaintiffs repeat their answers to paragraphs 1 through 11.

13. Plaintiffs deny the allegations of paragraph 13.

14. Plaintiffs deny the allegations of paragraph 14.

15. Plaintiffs deny the allegations of paragraph 15.

16. Plaintiffs deny the allegations of paragraph 16.

17. Plaintiffs deny the allegations of paragraph 17.

18. Plaintiffs deny the allegations of paragraph 18.

19. Plaintiffs deny the allegations of paragraph 19.

20. Plaintiffs admit that Susan sought medical attention for headaches; deny the remaining allegations of paragraph 20.

21. Plaintiffs deny the allegations of paragraph 21.

22. Plaintiffs deny the allegations of paragraph 22.

23. Plaintiffs deny the allegations of paragraph 23.

24. Plaintiffs deny the allegations of paragraph 24.

25. Plaintiffs admit the allegations of paragraph 25.

26. Plaintiffs admit the allegations of paragraph 26.

27. Plaintiffs admit the allegations of paragraph 27 but deny that defendant's request was proper, reasonable, or required under the contract.

28. Plaintiffs admit the allegations of paragraph 28 but deny that defendant's request was proper, reasonable, or required under the contract.

29. Plaintiffs admit the allegations of paragraph 29 but deny that defendant's request was proper, reasonable, or required under the contract.

30. Plaintiffs admit the allegations of paragraph 30 but deny that defendant's request was proper, reasonable, or required under the contract.

31. Plaintiffs admit the allegations of paragraph 31 but deny that defendant's action was proper, reasonable, or permitted under the contract.

32. Plaintiffs deny the allegations of paragraph 32.

33. Plaintiffs deny the allegations of paragraph 33.

34. Plaintiffs deny the allegations of paragraph 34.

35. Plaintiffs deny the allegations of paragraph 35.

36. Plaintiffs deny the allegations of paragraph 36.

37. Plaintiffs deny the allegations of paragraph 37.

38. Plaintiffs deny the allegations of paragraph 38.

39. Plaintiffs admit the allegations of paragraph 39 but deny that defendant's action was proper, reasonable, or permitted under the contract.

WHEREFORE, judgment on the counterclaim should be awarded to plaintiffs with costs assessed against plaintiff.

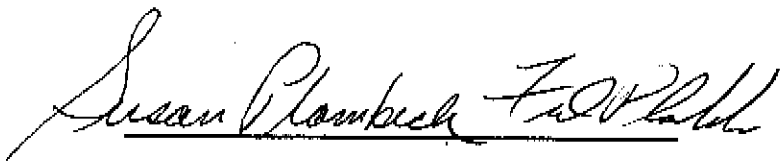
FRED PLAMBECK and SUSAN PLAMBECK, plaintiffs,

by _____
One of their attorneys

Douglas K. Morrison
MORRISON & MIX
Suite 2750
120 North La Salle Street
Chicago, Illinois 60602
312-726-0888
Attorney no. 17557

CERTIFICATION

Under penalties as provided by law pursuant to section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matter the undersigned certifies as aforesaid that (s)he verily believes the same to be true.



PROOF OF SERVICE

DOUGLAS K. MORRISON, an attorney, hereby certifies that one copy of the foregoing "Answer to Affirmative Defenses and Countercomplaint" was served upon Edna S. Bailey of Wilson, Elser, Moskowitz, Edelman & Dicker, LLP, 120 N. La Salle Street, Suite 2600, Chicago, Illinois, by hand delivery this 18th day of December, 2007.

Douglas K. Morrison